

List of Subjects**42 CFR part 431**

Grant programs-health, Health facilities, Medicaid, Privacy, Reporting and record keeping requirements.

42 CFR part 433

Administrative practice and procedure, Child support, Claims, Grant programs-health, Medicaid, Reporting and record keeping requirements.

42 CFR part 435

Aid to Families with Dependent Children, Grant programs-health, Medicaid, Reporting and record keeping requirements, Supplemental Security Income (SSI), Wages.

42 CFR part 436

Aid to Families with Dependent Children, Grant programs-health, Guam, Medicaid, Puerto Rico, Supplemental Security Income (SSI), Virgin Islands.

42 CFR part 457

Administrative practice and procedure, Grant programs-health, Children's Health Insurance Program, Reporting and record keeping requirements.

42 CFR chapter IV is amended as set forth below:

A. Part 431 is amended as follows:

PART 431 -- STATE ORGANIZATION AND GENERAL ADMINISTRATION

1. The authority citation for part 431 continues to read as follows:

Authority: Sec. 1102 of the Social Security Act, (42 U.S.C. 1302).

2. A new §431.636 is added to read as follows:

§431.636 Coordination of Medicaid with the State Children's Health Insurance Program (SCHIP).

(a) Statutory basis. This section implements --

(1) Section 2102(b)(3)(B) of the Act, which provides that children who apply for coverage under a separate child health plan under title XXI, but are found to be eligible for medical assistance under the State Medicaid plan, must be enrolled in the State Medicaid plan; and

(2) Section 2102(c)(2) of the Act, which requires coordination between a State child health program and other public health insurance programs.

(b) Obligations of State Medicaid Agency. The State Medicaid agency must adopt procedures to facilitate the Medicaid application process for, and the enrollment of children for whom the Medicaid application and enrollment

process has been initiated in accordance with §457.350(f) of this chapter. The procedures must ensure that --

(1) The applicant is not required to provide information or documentation that has been provided to the State agency responsible for determining eligibility under a separate child health program under title XXI and forwarded by such agency to the Medicaid agency on behalf of the child in accordance with §457.350(f) of this chapter;

(2) Eligibility is determined in a timely manner in accordance with §435.911 of this chapter;

(3) The Medicaid agency promptly notifies the State agency responsible for determining eligibility under a separate child health program when a child who was screened as potentially eligible for Medicaid is determined ineligible or eligible for Medicaid; and

(4) The Medicaid agency adopts a process that facilitates enrollment in a State child health program when a child is determined ineligible for Medicaid at initial application or redetermination.

3. In §431.865(b), the definition of "erroneous payments" is revised to read as follows:

§431.865 Disallowance of Federal financial participation for erroneous State payments (for annual assessment periods ending after July 1, 1990).

* * * * *

(b) * * *

Erroneous payments means the Medicaid payment that was made for an individual or family under review who --

(1) Was ineligible for the review month or, if full month coverage is not provided, at the time services were received;

(2) Was ineligible to receive a service provided during the review month; or

(3) Had not properly met enrollee liability requirements prior to receiving Medicaid services.

(4) The term does not include payments made for care and services covered under the State plan and furnished to children during a presumptive eligibility period as described in §435.1102 of this chapter.

* * * * *

B. Part 433 is amended as follows:

PART 433 -- STATE FISCAL ADMINISTRATION

1. The authority citation for part 433 is revised to read as follows:

Authority: Sec. 1102 of the Social Security Act, (42 U.S.C. 1302).

2. In §433.10, the heading of paragraph (c) is republished and a new paragraph (c)(4) is added to read as follows:

§433.10 Rates of FFP for program services.

* * * * *

(c) Special provisions.

* * *

(4) Under section 1905(b) of the Social Security Act, the Federal share of State expenditures described in §433.11(a) for services provided to children, is the enhanced FMAP rate determined in accordance with §457.622(b) of this chapter, subject to the conditions explained in §433.11(b).

3. A new §433.11 is added to read as follows:

§433.11 Enhanced FMAP rate for children

(a) Subject to the conditions in paragraph (b) of this section, the enhanced FMAP determined in accordance with §457.622 of this chapter will be used to determine the Federal share of State expenditures, except any expenditures pursuant to section 1923 of the Act for payments to disproportionate share hospitals for --

(1) Services provided to optional targeted low-income children described in §435.4 or §436.3 of this chapter; and

(2) Services provided to children born before October 1, 1983, with or without group health coverage or other health insurance coverage, who would be described in section 1902(1)(1)(D) of the Act (poverty-level-related children's groups) if --

(i) They had been born on or after that date; and

(ii) They would not qualify for medical assistance under the State plan in effect on March 31, 1997.

(b) Enhanced FMAP is not available if --

(1) A State adopts income and resource standards and methodologies for purposes of determining a child's

eligibility under the Medicaid State plan that are more restrictive than those applied under policies of the State plan (as described in the definition of optional targeted low-income children at §435.4) in effect on June 1, 1997; or

(2) No funds are available in the State's title XXI allotment, as determined under part 457, subpart F of this chapter for the quarter enhanced FMAP is claimed; or

(3) The State fails to maintain a valid method of identifying services provided on behalf of children listed in paragraph (a) of this section.

C. Part 435 is amended as set forth below:

**PART 435 -- ELIGIBILITY IN THE STATES, DISTRICT OF COLUMBIA,
THE NORTHERN MARIANA ISLANDS, AND AMERICAN SAMOA**

1. The authority citation for part 435 continues to read as follows:

Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

2. Section 435.4 is amended by adding a definition of "optional targeted low-income child," in alphabetical order, to read as follows:

§435.4 Definitions and use of terms.

* * * * *

Optional targeted low-income child means a child under age 19 who meets the financial and categorical standards described below.

(1) Financial need. An optional targeted low-income child:

(i) Has a family income at or below 200 percent of the Federal poverty line for a family of the size involved; and

(ii) Resides in a State with no Medicaid applicable income level (as defined at §457.10 of this chapter); or

(iii) Resides in a State that has a Medicaid applicable income level (as defined at §457.10 of this chapter) and has family income that either:

(A) Exceeds the Medicaid applicable income level for the age of such child, but not by more than 50 percentage points; or

(B) Does not exceed the income level specified for such child to be eligible for medical assistance under the policies of the State plan under title XIX on June 1, 1997.

(2) No other coverage and State maintenance of effort.
An optional targeted low-income child is not covered under a group health plan or health insurance coverage, or would not be eligible for Medicaid under the policies of the State plan in effect on March 31, 1997; except that, for purposes of this standard --

(i) A child shall not be considered to be covered by health insurance coverage based on coverage offered by the State under a program in operation prior to July 1, 1997 if that program received no Federal financial participation;

(ii) A child shall not be considered to be covered under a group health plan or health insurance coverage if the child did not have reasonable geographic access to care under that coverage.

(3) For purposes of this section, policies of the State plan a under title XIX plan include policies under a Statewide demonstration project under section 1115(a) of the Act other than a demonstration project that covered an expanded group of eligible children but that either --

(i) Did not provide inpatient hospital coverage; or

(ii) Limited eligibility to children previously enrolled in Medicaid, imposed premiums as a condition of initial or continued enrollment, and did not impose a general time limit on eligibility.

* * * * *

3. A new §435.229 is added to read as follows:

§435.229 Optional targeted low-income children.

The agency may provide Medicaid to--

(a) All individuals under age 19 who are optional targeted low-income children as defined in §435.4; or

(b) Reasonable categories of these individuals.

4. In §435.910, paragraph (h) is added to read as follows:

§435.910 Use of social security number.

* * * * *

(h) Exception. (1) A State may give a Medicaid identification number to an applicant who, because of well established religious objections, refuses to obtain a Social Security Number (SSN). The identification number may be

either an SSN obtained by the State on the applicant's behalf or another unique identifier.

(2) The term "well established religious objections" means that the applicant --

(i) Is a member of a recognized religious sect or division of the sect; and

(ii) Adheres to the tenets or teachings of the sect or division of the sect and for that reason is conscientiously opposed to applying for or using a national identification number.

(3) A State may use the Medicaid identification number established by the State to the same extent as an SSN is used for purposes described in paragraph (b)(3) of this section.

5. In §435.1001, paragraph (a) is revised to read as follows:

§435.1001 FFP for administration.

(a) FFP is available in the necessary administrative costs the State incurs in --

(1) Determining and redetermining Medicaid eligibility and in providing Medicaid to eligible individuals; and

(2) Determining presumptive eligibility for children and providing services to presumptively eligible children.

* * * * *

6. Section 435.1002 is amended by adding a new paragraph (c) to read as follows:

§435.1002 FFP for services.

* * * * *

(c) FFP is available in expenditures for services covered under the plan that are furnished --

(1) To children who are determined by a qualified entity to be presumptively eligible;

(2) During a period of presumptive eligibility;

(3) By a provider that is eligible for payment under the plan; and

(4) Regardless of whether the children are determined eligible for Medicaid following the period of presumptive eligibility.

§435.1007 [Amended]

7. In §435.1007, in paragraph (a), the second sentence is amended by adding "and section 1905(u)" between "(X)", and "of the Act;".

8. A new subpart L is added to part 435 to read as follows:

Subpart L--Option for Coverage of Special Groups

Sec.

435.1100 Basis and scope.

Presumptive Eligibility for Children

435.1101 Definitions related to presumptive eligibility for children.

435.1102 General Rules.

Subpart L--Option for Coverage of Special Groups

§435.1100 Basis and scope.

(a) Statutory basis. Section 1920A of the Act allows States to provide Medicaid services to children under age 19 during a period of presumptive eligibility, prior to a formal determination of Medicaid eligibility.

(b) Scope. This subpart prescribes the requirements for providing medical assistance to special groups who are not eligible for Medicaid as categorically or medically needy.

PRESUMPTIVE ELIGIBILITY FOR CHILDREN

§435.1101 Definitions related to presumptive eligibility for children.

Application form means at a minimum the form used to apply for Medicaid under the poverty-level-related eligibility groups described in section 1902(1) of the Act or a joint form for children to apply for the State Children's Health Insurance Program and Medicaid.

Period of presumptive eligibility means a period that begins on the date on which a qualified entity determines that a child is presumptively eligible and ends with the earlier of --

(1) In the case of a child on whose behalf a Medicaid application has been filed, the day on which a decision is made on that application; or

(2) In the case of a child on whose behalf a Medicaid application has not been filed, the last day of the month

following the month in which the determination of presumptive eligibility was made.

Presumptive income standard means the highest income eligibility standard established under the plan that is most likely to be used to establish the regular Medicaid eligibility of a child of the age involved.

Qualified entity means an entity that is determined by the State to be capable of making determinations of presumptive eligibility for children, and that --

(1) Furnishes health care items and services covered under the approved plan and is eligible to receive payments under the approved plan;

(2) Is authorized to determine eligibility of a child to participate in a Head Start program under the Head Start Act;

(3) Is authorized to determine eligibility of a child to receive child care services for which financial assistance is provided under the Child Care and Development Block Grant Act of 1990;

(4) Is authorized to determine eligibility of an infant or child to receive assistance under the special nutrition

program for women, infants, and children (WIC) under section 17 of the Child Nutrition Act of 1966;

(5) Is an elementary or secondary school, as defined in section 14101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 8801);

(6) Is an elementary or secondary school operated or supported by the Bureau of Indian Affairs;

(7) Is a State or Tribal child support enforcement agency;

(8) Is an organization that is providing emergency food and shelter under a grant under the Stewart B. McKinney Homeless Assistance Act;

(9) Is a State or Tribal office or entity involved in enrollment in the program under Part A of title IV, title XIX, or title XXI; or

(10) Is an entity that determines eligibility for any assistance or benefits provided under any program of public or assisted housing that receives Federal funds, including the program under section 8 or any other section of the United States Housing Act of 1937 (42 U.S.C. 1437) or under the Native American Housing Assistance and Self Determination Act of 1996 (25 U.S.C. 4101 et seq.); or

(11) Any other entity the State so deems, as approved by the Secretary.

Services means all services covered under the plan including EPSDT (see part 440 of this chapter.)

§435.1102 General rules.

(a) The agency may provide services to children under age 19 during one or more periods of presumptive eligibility following a determination by a qualified entity that the child's estimated gross family income or, at the State's option, the child's estimated family income after applying simple disregards, does not exceed the applicable income standard.

(b) If the agency elects to provide services to children during a period of presumptive eligibility, the agency must --

(1) Provide qualified entities with application forms for Medicaid and information on how to assist parents, caretakers and other persons in completing and filing such forms;

(2) Establish procedures to ensure that qualified entities --

(i) Notify the parent or caretaker of the child at the time a determination regarding presumptive eligibility is made, in writing and orally if appropriate, of such determination;

(ii) Provide the parent or caretaker of the child with a regular Medicaid application form;

(iii) Within five working days after the date that the determination is made, notify the agency that a child is presumptively eligible;

(iv) For children determined to be presumptively eligible, notify the child's parent or caretaker at the time the determination is made, in writing and orally if appropriate, that --

(A) If a Medicaid application on behalf of the child is not filed by the last day of the following month, the child's presumptive eligibility will end on that last day; and

(B) If a Medicaid application on behalf of the child is filed by the last day of the following month, the child's presumptive eligibility will end on the day that a decision is made on the Medicaid application; and

(v) For children determined not to be presumptively eligible, notify the child's parent or caretaker at the time the determination is made, in writing and orally if appropriate--

(A) Of the reason for the determination; and

(B) That he or she may file an application for Medicaid on the child's behalf with the Medicaid agency;

(3) Provide all services covered under the plan, including EPSDT; and

(4) Allow determinations of presumptive eligibility to be made by qualified entities on a Statewide basis.

(c) The agency must adopt reasonable standards regarding the number of periods of presumptive eligibility that will be authorized for a child in a given time frame.

D. Part 436 is amended as set forth below:

PART 436 -- ELIGIBILITY IN GUAM, PUERTO RICO, AND THE VIRGIN ISLANDS

1. The authority citation for part 436 continues to read as follows:

Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

2. Section 436.3 is amended by adding a definition of "optional targeted low-income child," in alphabetical order, to read as follows:

§436.3 Definitions and use of terms.

* * * * *

Optional targeted low-income child means a child under age 19 who meets the financial and categorical standards described below.

(1) Financial need. An optional targeted low-income child:

(i) Has a family income at or below 200 percent of the Federal poverty line for a family of the size involved;

(ii) Resides in a State with no Medicaid applicable income level (as defined in §457.10 of this chapter); or,

(iii) Resides in a State that has a Medicaid applicable income level (as defined in §457.10) and has family income that either:

(A) Exceeds the Medicaid applicable income level for the age of such child, but not by more than 50 percentage points (expressed as a percentage of the Federal poverty line); or

(B) Does not exceed the income level specified for such child to be eligible for medical assistance under the policies of the State plan under title XIX on June 1, 1997.

(2) No other coverage and State maintenance of effort.
An optional targeted low-income child is not covered under a group health plan or health insurance coverage, or would not be eligible for Medicaid under the policies of the State plan in effect on March 31, 1997; except that, for purposes of this standard --

(i) A child shall not be considered to be covered by health insurance coverage based on coverage offered by the State under a program in operation prior to July 1, 1997 if that program received no Federal financial participation;

(ii) A child shall not be considered to be covered under a group health plan or health insurance coverage if the child did not have reasonable geographic access to care under that coverage.

(3) For purposes of this section, policies of the State plan a under title XIX plan include policies under a Statewide demonstration project under section 1115(a) of the Act other than a demonstration project that covered an expanded group of eligible children but that either --

(i) Did not provide inpatient hospital coverage; or

(ii) Limited eligibility to children previously enrolled in Medicaid, imposed premiums as a condition of initial or continued enrollment, and did not impose a general time limit on eligibility.

3. A new §436.229 is added to read as follows:

§436.229 Optional targeted low-income children.

The agency may provide Medicaid to--

(a) All individuals under age 19 who are optional targeted low-income children as defined in §436.3; or

(b) Reasonable categories of these individuals.

4. In §436.1001 paragraph (a) is revised to read as follows:

§436.1001 FFP for administration.

(a) FFP is available in the necessary administrative costs the State incurs in --

(1) Determining and redetermining Medicaid eligibility and in providing Medicaid to eligible individuals; and

(2) Determining presumptive eligibility for children and providing services to presumptively eligible children.

* * * * *

5. Section 436.1002 is amended by adding a new paragraph (c) to read as follows:

§436.1002 FFP for services.

* * * * *

(c) FFP is available in expenditures for services covered under the plan that are furnished --

(1) To children who are determined by a qualified entity to be presumptively eligible;

(2) During a period of presumptive eligibility;

(3) By a provider that is eligible for payment under the plan; and

(4) Regardless of whether the children are determined eligible for Medicaid following the period of presumptive eligibility.

6. A new subpart L is added to part 436 to read as follows:

Subpart L--Option for Coverage of Special Groups

Sec.

436.1100 Basis and scope.

Presumptive Eligibility for Children

436.1101 Definitions related to presumptive eligibility for children.

436.1102 General Rules.

Subpart L--Option for Coverage of Special Groups

§436.1100 Basis and scope.

(a) Statutory basis. Section 1920A of the Act allows States to provide Medicaid services to children under age 19

during a period of presumptive eligibility, prior to a formal determination of Medicaid eligibility.

(b) Scope. This subpart prescribes the requirements for providing medical assistance to special groups who are not eligible for Medicaid as categorically or medically needy.

PRESUMPTIVE ELIGIBILITY FOR CHILDREN

§436.1101 Definitions related to presumptive eligibility period for children.

Application form means at a minimum the form used to apply for Medicaid under the poverty-level-related eligibility groups described in section 1902(1) of the Act or a joint form for children to apply for the State Children's Health Insurance Program and Medicaid.

Period of presumptive eligibility means a period that begins on the date on which a qualified entity determines that a child is presumptively eligible and ends with the earlier of --

(1) In the case of a child on whose behalf a Medicaid application has been filed, the day on which a decision is made on that application; or

(2) In the case of a child on whose behalf a Medicaid application has not been filed, the last day of the month following the month in which the determination of presumptive eligibility was made.

Presumptive income standard means the highest income eligibility standard established under the plan that is most likely to be used to establish the regular Medicaid eligibility of a child of the age involved.

Qualified entity means an entity that is determined by the State to be capable of making determinations of presumptive eligibility for children, and that --

(1) Furnishes health care items and services covered under the approved plan and is eligible to receive payments under the approved plan;

(2) Is authorized to determine eligibility of a child to participate in a Head Start program under the Head Start Act;

(3) Is authorized to determine eligibility of a child to receive child care services for which financial assistance is provided under the Child Care and Development Block Grant Act of 1990;

(4) Is authorized to determine eligibility of an infant or child to receive assistance under the special nutrition program for women, infants, and children (WIC) under section 17 of the Child Nutrition Act of 1966;

(5) Is an elementary or secondary school, as defined in section 14101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 8801);

(6) Is an elementary or secondary school operated or supported by the Bureau of Indian Affairs;

(7) Is a State or Tribal child support enforcement agency;

(8) Is an organization that is providing emergency food and shelter under a grant under the Stewart B. McKinney Homeless Assistance Act;

(9) Is a State or Tribal office or entity involved in enrollment in the program under Part A of title IV, title XIX, or title XXI; or

(10) Is an entity that determines eligibility for any assistance or benefits provided under any program of public or assisted housing that receives Federal funds, including the program under section 8 or any other section of the United States Housing Act of 1937 (42 U.S.C. 1437) or under

the Native American Housing Assistance and Self Determination Act of 1996 (25 U.S.C. 4101 et seq.); or

(11) Any other entity the State so deems, as approved by the Secretary.

Services means all services covered under the plan including EPSDT (see part 440 of this chapter.)

§436.1102 General rules.

(a) The agency may provide services to children under age 19 during one or more periods of presumptive eligibility following a determination made by a qualified entity that the child's estimated gross family income or, at the State's option, the child's estimated family income after applying simple disregards, does not exceed the applicable income standard.

(b) If the agency elects to provide services to children during a period of presumptive eligibility, the agency must --

(1) Provide qualified entities with application forms for Medicaid and information on how to assist parents, caretakers and other persons in completing and filing such forms;

(2) Establish procedures to ensure that qualified entities --

(i) Notify the parent or caretaker of the child at the time a determination regarding presumptive eligibility is made, in writing and orally if appropriate, of such determination;

(ii) Provide the parent or caretaker of the child with a Medicaid application form;

(iii) Within 5 working days after the date that the determination is made, notify the agency that a child is presumptively eligible;

(iv) For children determined to be presumptively eligible, notify the child's parent or caretaker at the time the determination is made, in writing and orally if appropriate, that --

(A) If a Medicaid application on behalf of the child is not filed by the last day of the following month, the child's presumptive eligibility will end on that last day; and

(B) If a Medicaid application on behalf of the child is filed by the last day of the following month, the child's

presumptive eligibility will end on the day that a decision is made on the Medicaid application; and

(v) For children determined not to be presumptively eligible, notify the child's parent or caretaker at the time the determination is made, in writing and orally if appropriate--

(A) Of the reason for the determination; and

(B) That he or she may file an application for Medicaid on the child's behalf with the Medicaid agency; and

(3) Provide all services covered under the plan, including EPSDT.

(4) Allow determinations of presumptive eligibility to be made by qualified entities on a Statewide basis.

(c) The agency must adopt reasonable standards regarding the number of periods of presumptive eligibility that will be authorized for a child in a given time frame.

E. Part 457 is amended as follows:

PART 457--ALLOTMENTS AND GRANTS TO STATES

1. The authority citation for part 457 continues to read as follows:

Authority: Section 1102 of the Social Security Act (42 U.S. C. 1302).

2. A new subpart A is added to read as follows:

Subpart A -- Introduction; State Plans for Child Health Insurance Programs and Outreach Strategies

Sec.

457.1 Program description.

457.2 Basis and scope of subchapter D.

457.10 Definitions and use of terms.

457.30 Basis, scope, and applicability of subpart A.

457.40 State program administration.

457.50 State plan.

457.60 Amendments.

457.65 Effective date and duration of State plans and plan amendments.

- 457.70 Program options.
- 457.80 Current State child health insurance coverage and
 coordination.
- 457.90 Outreach.
- 457.110 Enrollment assistance and information requirements.
- 457.120 Public involvement in program development.
- 457.125 Provision of child health assistance to American
 Indian and Alaska Native children.
- 457.130 Civil rights assurance.
- 457.135 Assurance of compliance with other provisions.
- 457.140 Budget.
- 457.150 HCFA review of State plan material.
- 457.160 Notice and timing of HCFA action on State plan
 material.
- 457.170 Withdrawal process.

Subpart A -- Introduction; State Plans for Child Health Insurance Programs and Outreach Strategies

§457.1 Program description.

Title XXI of the Social Security Act, enacted in 1997 by the Balanced Budget Act, authorizes Federal grants to States for provision of child health assistance to uninsured, low-income children. The program is jointly financed by the Federal and State governments and administered by the States. Within broad Federal rules, each State decides eligible groups, types and ranges of services, payment levels for benefit coverage, and administrative and operating procedures.

§457.2 Basis and scope of subchapter D.

(a) Basis. This subchapter implements title XXI of the Act, which authorizes Federal grants to States for the provision of child health assistance to uninsured, low-income children.

(b) Scope. The regulations in subchapter D set forth State plan requirements, standards, procedures, and conditions for obtaining Federal financial participation (FFP) to enable States to provide health benefits coverage

to targeted low-income children, as defined at §457.310.

§457.10 Definitions and use of terms.

For purposes of this part the following definitions apply:

American Indian/Alaska Native (AI/AN) means--

(1) A member of a Federally recognized Indian tribe, band, or group;

(2) An Eskimo or Aleut or other Alaska Native enrolled by the Secretary of the Interior pursuant to the Alaska Native Claims Settlement Act, 43 U.S.C. 1601 *et. seq.*; or

(3) A person who is considered by the Secretary of the Interior to be an Indian for any purpose.

Applicant means a child who has filed an application (or who has an application filed on their behalf) for health benefits coverage through the State Children's Health Insurance Program. A child is an applicant until the child receives coverage through SCHIP.

Child means an individual under the age of 19.

Child health assistance means payment for part or all of the cost of health benefits coverage provided to targeted low-income children for the services listed at §457.402.

Combination program means a program under which a State implements both a Medicaid expansion program and a separate child health program.

Cost sharing means premium charges, enrollment fees, deductibles, coinsurance, copayments, or other similar fees that the enrollee has responsibility for paying.

Creditable health coverage has the meaning given the term "creditable coverage" at 45 CFR 146.113 and includes coverage that meets the requirements of §457.410 and is provided to a targeted low-income child.

Emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in --

(1) Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of a woman or her unborn child;

(2) Serious impairment of bodily function; or

(3) Serious dysfunction of any bodily organ or part.

Emergency services means health care services that are --

(1) Furnished by any provider qualified to furnish such services; and

(2) Needed to evaluate, treat, or stabilize an emergency medical condition.

Enrollee means a child who receives health benefits coverage through SCHIP.

Enrollment cap means a limit, established by the State in its State plan, on the total number of children permitted to enroll in a State's separate child health program .

Family income means income as determined by the State for a family as defined by the State.

Federal fiscal year starts on the first day of October each year and ends on the last day of the following September.

Fee-for-service entity has the meaning assigned in §457.902.

Group health insurance coverage has the meaning assigned at 45 CFR 144.103.

Group health plan has the meaning assigned at 45 CFR 144.103.

Health benefits coverage means an arrangement under which enrolled individuals are protected from some or all liability for the cost of specified health care services.

Health care services means any of the services, devices, supplies, therapies, or other items listed in §457.402.

Health insurance coverage has the meaning assigned at 45 CFR 144.103.

Health insurance issuer has the meaning assigned at 45 CFR 144.103.

Health maintenance organization (HMO) plan has the meaning assigned at §457.420.

Health services initiatives means activities that protect the public health, protect the health of individuals, improve or promote a State's capacity to deliver public health services, or strengthen the human and material resources necessary to accomplish public health goals relating to improving the health of children (including targeted low-income children and other low-income children).

Joint application has the meaning assigned at §457.301.

Low-income child means a child whose family income is at or below 200 percent of the poverty line for the size of the family involved.

Managed care entity (MCE) means an entity that enters into a contract to provide services in a managed care delivery system, including but not limited to managed care organizations, prepaid health plans, and primary care case managers.

Medicaid applicable income level means, with respect to a child, the effective income level (expressed as a percentage of the poverty line) specified under the policies of the State plan under title XIX of the Act (including for these purposes, a section 1115 waiver authorized by the Secretary or under the authority of section 1902(r)(2) of the Act) as of March 31, 1997 for the child to be eligible for medical assistance under either section 1902(l)(2) or 1905(n)(2) of the Act.

Medicaid expansion program means a program under which a State receives Federal funding to expand Medicaid eligibility to optional targeted low-income children.

Optional targeted low-income child has the meaning assigned at §435.4 (for States) and §436.3 (for Territories) of this chapter.

Period of presumptive eligibility has the meaning assigned at §457.301.

Poverty line/Federal poverty level means the poverty guidelines updated annually in the **Federal Register** by the U.S. Department of Health and Human Services under authority of 42 U.S.C. 9902(2).

Preexisting condition exclusion has the meaning assigned at 45 CFR 144.103.

Premium assistance program means a component of a separate child health program, approved under the State plan, under which a State pays part or all of the premiums for a SCHIP enrollee or enrollees' group health insurance coverage or coverage under a group health plan.

Presumptive income standard has the meaning assigned at §457.301.

Public agency has the meaning assigned in §457.301.

Qualified entity has the meaning assigned at §457.301.

Separate child health program means a program under which a State receives Federal funding from its title XXI allotment to provide child health assistance through obtaining coverage that meets the requirements of section 2103 of the Act and §457.402.

State means all States, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa and the Northern Mariana Islands. The Territories are excluded from this definition for purposes of §457.740.

State Children's Health Insurance Program (SCHIP) means a program established and administered by a State, jointly funded with the Federal government, to provide child health assistance to uninsured, low-income children through a separate child health program, a Medicaid expansion program, or a combination program.

State health benefits plan has the meaning assigned in §457.301.

State plan means the title XXI State child health plan.

Targeted low-income child has the meaning assigned in §457.310.

Uncovered or uninsured child means a child who does not have creditable health coverage.

Well-baby and well-child care services means regular or preventive diagnostic and treatment services necessary to ensure the health of babies, children and adolescents as defined by the State. For purposes of cost sharing, the term has the meaning assigned at §457.520.

§457.30 Basis, scope, and applicability of subpart A.

(a) Statutory basis. This subpart implements the following sections of the Act:

(1) Section 2101(b), which requires that the State submit a State plan.

(2) Section 2102(a), which sets forth requirements regarding the contents of the State plan.

(3) Section 2102(b), which relates to eligibility standards and methodologies.

(4) Section 2102(c), which requires that the State plan include a description of the procedures to be used by the State to accomplish outreach and coordination with other health insurance programs.

(5) Section 2106, which specifies the process for submission, approval, and amendment of State plans.

(6) Section 2107(c), which requires that the State plan include a description of the process used to involve the public in the design and implementation of the plan.

(7) Section 2107(d), which requires that the State plan include a description of the budget for the plan.

(8) Section 2107(e), which provides that certain provisions of title XIX and title XI of the Act apply under title XXI in the same manner that they apply under title XIX.

(b) Scope. This subpart sets forth provisions governing the administration of SCHIP, the general requirements for a State plan, and a description of the process for review of a State plan or plan amendment.

(c) Applicability. This subpart applies to all States that request Federal financial participation to provide child health assistance under title XXI.

§457.40 State program administration.

(a) Program operation. The State must implement its program in accordance with the approved State plan, any

approved State plan amendments, the requirements of title XXI and title XIX (as appropriate), and the requirements in this chapter. HCFA monitors the operation of the approved State plan and plan amendments to ensure compliance with the requirements of title XXI, title XIX (as appropriate) and this chapter.

(b) State authority to submit State plan. A State plan or plan amendment must be signed by the State Governor, or signed by an individual who has been delegated authority by the Governor to submit it.

(c) State program officials. The State must identify in the State plan or State plan amendment, by position or title, the State officials who are responsible for program administration and financial oversight.

(d) State legislative authority. The State plan must include an assurance that the State will not claim expenditures for child health assistance prior to the time that the State has legislative authority to operate the State plan or plan amendment as approved by HCFA.

§457.50 State plan.

The State plan is a comprehensive written statement, submitted by the State to HCFA for approval, that describes

the purpose, nature, and scope of the State's SCHIP and gives an assurance that the program is administered in conformity with the specific requirements of title XXI, title XIX (as appropriate), and the regulations in this chapter. The State plan contains all information necessary for HCFA to determine whether the plan can be approved to serve as a basis for Federal financial participation (FFP) in the State program.

§457.60 Amendments.

A State may seek to amend its approved State plan in whole or in part at any time through the submission of an amendment to HCFA. When the State plan amendment has a significant impact on the approved budget, the amendment must include an amended budget that describes the State's planned expenditures for a 1-year period. A State must amend its State plan whenever necessary to reflect--

(a) Changes in Federal law, regulations, policy interpretations, or court decisions that affect provisions in the approved State plan;

(b) Changes in State law, organization, policy, or operation of the program that affect the following program elements described in the State plan:

(1) Eligibility standards, enrollment caps, and disenrollment policies as described in §457.305.

(2) Procedures to prevent substitution of private coverage, including exemptions or exceptions to required eligibility waiting periods without coverage under a group health plan as described §457.810.

(3) The type of health benefits coverage offered, consistent with the options described in §457.410.

(4) Addition or deletion of specific categories of benefits covered under the State plan.

(5) Basic delivery system approach as described in §457.490.

(6) Cost-sharing as described in §457.505.

(7) Screen and enroll procedures, and other Medicaid coordination procedures as described in §§457.350 and 457.353.

(8) Review procedures as described in §§457.1130, 457.1160, 457.1170, 457.1180 and 457.1190.

(9) Other comparable required program elements.

(c) Changes in the source of the State share of funding, except for changes in the type of non-health care related revenues used to generate general revenue.

§457.65 Effective date and duration of State plans and plan amendments.

(a) Effective date in general. Except as otherwise limited by this section --

(1) A State plan or plan amendment takes effect on the day specified in the plan or plan amendment, but no earlier than October 1, 1997.

(2) The effective date may be no earlier than the date on which the State begins to incur costs to implement its State plan or plan amendment.

(3) A State plan amendment that takes effect prior to submission of the amendment to HCFA may remain in effect only until the end of the State fiscal year in which the State makes it effective, or, if later, the end of the 90-day period following the date on which the State makes it effective, unless the State submits the amendment to HCFA for approval before the end of that State fiscal year or that 90-day period.

(b) Amendments relating to eligibility or benefits. A State plan amendment that eliminates or restricts eligibility or benefits may not be in effect for longer than a 60-day period, unless the amendment is submitted to HCFA before the end of that 60-day period. The amendment may not take effect unless--

(1) The State certifies that it has provided prior public notice of the proposed change in a form and manner provided under applicable State law; and

(2) The public notice was published before the requested effective date of the change.

(c) Amendments relating to cost sharing. A State plan amendment that implements cost-sharing charges, increases existing cost-sharing charges, or increases the cumulative cost-sharing maximum as set forth at §457.560 is considered an amendment that restricts benefits and must meet the requirements in paragraph (b) of this section.

(d) Amendments relating to enrollment procedures. A State plan amendment that implements a required period of uninsurance, increases the length of existing required periods of uninsurance, or institutes or extends the use of waiting lists, enrollments caps or closed enrollment periods

is considered an amendment that restricts eligibility and must meet the requirements in paragraph (b) of this section.

(e) Amendments relating to the source of State funding. A State plan amendment that changes the source of the State share of funding can take effect no earlier than the date of submission of the amendment.

(f) Continued approval. An approved State plan continues in effect unless--

(1) The State adopts a new plan by obtaining approval under §457.60 of an amendment to the State plan;

(2) Withdraws its plan in accordance with §457.170(b);
or

(3) The Secretary finds substantial noncompliance of the plan with the requirements of the statute or regulations.

§457.70 Program options.

(a) Health benefits coverage options. A State may elect to obtain health benefits coverage under its plan through--

(1) A separate child health program;

(2) A Medicaid expansion program; or

(3) A combination program.

(b) State plan requirement. A State must include in the State plan or plan amendment a description of the State's chosen program option.

(c) Medicaid expansion program requirements. A State plan under title XXI for a State that elects to obtain health benefits coverage through its Medicaid plan must--

(1) Meet the requirements of --

(i) Subpart A;

(ii) Subpart B (to the extent that the State claims administrative costs under title XXI);

(iii) Subpart F (with respect to determination of the allotment for purposes of the enhanced matching rate, determination of the enhanced matching rate, and payment of any claims for administrative costs under title XXI only);

(iv) Subpart G; and

(v) Subpart J (if the State claims administrative costs under title XXI and seeks a waiver of limitations on such claims based on a community based health delivery system).

(2) Be consistent with the State's Medicaid State plan, or an approvable amendment to that plan, as required under title XIX .

(d) Separate child health program requirements. A State that elects to obtain health benefits coverage under its plan through a separate child health program must meet all the requirements of part 457.

(e) Combination program requirements. A State that elects to obtain health benefits coverage through both a separate child health program and a Medicaid expansion program must meet the requirements of paragraphs (c) and (d) of this section.

§457.80 Current State child health insurance coverage and coordination.

A State plan must include a description of--

(a) The extent to which, and manner in which, children in the State, including targeted low-income children and other classes of children, by income level and other relevant factors, currently have creditable health coverage (as defined in §457.10) and, if sufficient information is available, whether the creditable health coverage they have

is under public health insurance programs or health insurance programs that involve public-private partnerships;

(b) Current State efforts to provide or obtain creditable health coverage for uncovered children, including the steps the State is taking to identify and enroll all uncovered children who are eligible to participate in public health insurance programs and health insurance programs that involve public-private partnerships; and

(c) Procedures the State uses to accomplish coordination of SCHIP with other public and private health insurance programs, sources of health benefits coverage for children, and relevant child health programs, such as title V, that provide health care services for low-income children. Such procedures include those designed to --

(1) Increase the number of children with creditable health coverage;

(2) Assist in the enrollment in SCHIP of children determined ineligible for Medicaid; and

(3) Ensure that only eligible targeted low-income children are covered under SCHIP, such as those procedures required under §§457.350 and 457.353, as applicable.

§457.90 Outreach.

(a) Procedures required. A State plan must include a description of procedures used to inform families of children likely to be eligible for child health assistance under the plan or under other public or private health coverage programs of the availability of the programs, and to assist them in enrolling their children in one of the programs.

(b) Examples. Outreach strategies may include but are not limited to the following:

(1) Education and awareness campaigns, including targeted mailings and information distribution through various organizations.

(2) Enrollment simplification, such as simplified or joint application forms.

(3) Application assistance, including opportunities to apply for child health assistance under the plan through community-based organizations and in combination with other benefits and services available to children.

§457.110 Enrollment assistance and information requirements.

(a) Information disclosure. The State must make accurate, easily understood, linguistically appropriate information available to families of potential applicants,

applicants and enrollees, and provide assistance to these families in making informed decisions about their health plans, professionals, and facilities.

(b) Required information. The State must make available to potential applicants and provide applicants and enrollees the following information in a timely manner:

(1) Types of benefits, and amount, duration and scope of benefits available under the program.

(2) Cost-sharing requirements as described in §457.525.

(3) Names and locations of current participating providers.

(4) If an enrollment cap is in effect or the State is using a waiting list, a description of the procedures relating to the cap or waiting list, including the process for deciding which children will be given priority for enrollment, how children will be informed of their status on a waiting list and the circumstances under which enrollment will reopen.

(5) Information on physician incentive plans as required by §457.985.

(6) Review processes available to applicants and enrollees as described in the State plan pursuant to §457.1120.

§457.120 Public involvement in program development.

A State plan must include a description of the method the State uses to--

(a) Involve the public in both the design and initial implementation of the program;

(b) Ensure ongoing public involvement once the State plan has been implemented; and

(c) Ensure interaction with Indian Tribes and organizations in the State on the development and implementation of the procedures required at §457.125.

§457.125 Provision of child health assistance to American Indian and Alaska Native children.

(a) Enrollment. A State must include in its State plan a description of procedures used to ensure the provision of child health assistance to American Indian and Alaska Native children.

(b) Exemption from cost sharing. The procedures required by paragraph (a) of this section must include an

exemption from cost sharing for American Indian and Alaska Native children in accordance with §457.535.

§457.130 Civil rights assurance.

The State plan must include an assurance that the State will comply with all applicable civil rights requirements, including title VI of the Civil Rights Act of 1964, title II of the Americans with Disabilities Act of 1990, section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, 45 CFR part 80, part 84, and part 91, and 28 CFR part 35.

§457.135 Assurance of compliance with other provisions.

The State plan must include an assurance that the State will comply, under title XXI, with the following provisions of titles XIX and XI of the Social Security Act:

(a) Section 1902(a)(4)(C) (relating to conflict of interest standards).

(b) Paragraphs (2), (16) and (17) of section 1903(i) (relating to limitations on payment).

(c) Section 1903(w) (relating to limitations on provider donations and taxes).

(d) Section 1132 (relating to periods within which claims must be filed).

§457.140 Budget.

The State plan, or plan amendment that has a significant impact on the approved budget, must include a budget that describes the State's planned expenditures for a 1-year period. The budget must describe --

(a) Planned use of funds, including--

(1) Projected amount to be spent on health services;

(2) Projected amount to be spent on administrative costs, such as outreach, child health initiatives, and evaluation; and

(3) Assumptions on which the budget is based, including cost per child and expected enrollment; and

(b) Projected sources of non-Federal plan expenditures, including any requirements for cost sharing by enrollees.

§457.150 HCFA review of State plan material.

(a) Basis for action. HCFA reviews each State plan and plan amendment to determine whether it meets or

continues to meet the requirements for approval under relevant Federal statutes, regulations, and guidelines furnished by HCFA to assist in the interpretation of these regulations.

(b) Action on complete plan. HCFA approves or disapproves the State plan or plan amendment only in its entirety.

(c) Authority. The HCFA Administrator exercises delegated authority to review and then to approve or disapprove the State plan or plan amendment, or to determine that previously approved material no longer meets the requirements for approval. The Administrator does not make a final determination of disapproval without first consulting the Secretary.

(d) Initial submission. The Administrator designates an official to receive the initial submission of State plans.

(e) Review process. (1) The Administrator designates an individual to coordinate HCFA's review for each State that submits a State plan.

(2) HCFA notifies the State of the identity of the designated individual in the first correspondence relating

to that plan, and at any time there is a change in the designated individual.

(3) In the temporary absence of the designated individual during regular business hours, an alternate individual will act in place of the designated individual.

§457.160 Notice and timing of HCFA action on State plan material.

(a) Notice of final determination. The Administrator provides written notification to the State of the approval or disapproval of a State plan or plan amendment.

(b) Timing. (1) A State plan or plan amendment will be considered approved unless HCFA, within 90 calendar days after receipt of the State plan or plan amendment in the HCFA central office, sends the State--

(i) Written notice of disapproval; or

(ii) Written notice of additional information it needs in order to make a final determination.

(2) A State plan or plan amendment is considered received when the designated official or individual, as determined in §457.150(d) and (e), receives an electronic, fax or paper copy of the complete material.

(3) If HCFA requests additional information, the 90-day review period for HCFA action on the State plan or plan amendment --

(i) Stops on the day HCFA sends a written request for additional information or the next business day if the request is sent on a Federal holiday or weekend; and

(ii) Resumes on the next calendar day after the HCFA designated individual receives an electronic, fax, or hard copy from the State of all the requested additional information, unless the information is received after 5 p.m. eastern standard time on a day prior to a non-business day or any time on a non-business day, in which case the review period resumes on the following business day.

(4) The 90-day review period cannot stop or end on a non-business day. If the 90th calendar day falls on a non-business day, HCFA will consider the 90th day to be the next business day.

(5) HCFA may send written notice of its need for additional information as many times as necessary to obtain the complete information necessary to review the State plan or plan amendment.

§457.170 Withdrawal process.

(a) Withdrawal of proposed State plans or plan amendments. A State may withdraw a proposed State plan or plan amendment, or any portion of a proposed State plan or plan amendment, at any time during the review process by providing written notice to HCFA of the withdrawal.

(b) Withdrawal of approved State plans. A State may request withdrawal of an approved State plan by submitting a State plan amendment to HCFA in accordance with §457.60.

**Subpart B -- General Administration -- Reviews and Audits;
Withholding for Failure to Comply; Deferral and Disallowance
of Claims; Reduction of Federal Medical Payments**

3. A new §457.203 is added to read as follows:

**§457.203 Administrative and judicial review of action on
State plan material.**

(a) Request for reconsideration. Any State dissatisfied with the Administrator's action on State plan material under §457.150 may, within 60 days after receipt of the notice of final determination provided under §457.160(a), request that the Administrator reconsider

whether the State plan or plan amendment conforms with the requirements for approval.

(b) Notice of hearing. Within 30 days after receipt of the request, the Administrator notifies the State of the time and place of a hearing to be held for the purpose of reconsideration.

(c) Hearing procedures. The hearing procedures set forth in part 430, subpart D of this chapter govern a hearing requested under this section.

(d) Effect of hearing decision. HCFA does not delay the denial of Federal funds, if required by the Administrator's original determination, pending a hearing decision. If the Administrator determines that his or her original decision was incorrect, HCFA will pay the State a lump sum equal to any funds incorrectly denied.

4. Paragraph (d)(2) of §457.204 is revised to read as follows:

§457.204 Withholding of payment for failure to comply with Federal requirements.

* * * * *

(d) * * *

(2) Opportunity for corrective action. If enforcement actions are proposed, the State must submit evidence of corrective action related to the findings of noncompliance to the Administrator within 30 days from the date of the preliminary notification. Corrective action is action to ensure that the plan is, and will be, administered consistent with applicable law and regulations, to ameliorate past deficiencies in plan administration, or to ensure that enrollees will be treated equitably.

* * * * *

5. Paragraph (a) of §457.208 is revised to read as follows:

§457.208 Judicial review.

(a) Right to judicial review. Any State dissatisfied with the Administrator's final determination on approvability of plan material (§457.203) or compliance with Federal requirements (§457.204) has a right to judicial review.

* * * * *

§457.234 [Removed]

6. Section 457.234 is removed.

7. New subparts C, D, and E are added to read as follows:

Subpart C -- State Plan Requirements: Eligibility, Screening, Applications, and Enrollment

Sec.

457.300 Basis, scope, and applicability.

457.301 Definitions and use of terms.

457.305 State plan provisions.

457.310 Targeted low-income child.

457.320 Other eligibility standards.

457.340 Application for and enrollment in a separate child health program.

457.350 Eligibility screening and facilitation of Medicaid enrollment.

457.353 Monitoring and evaluation of screening process.

457.355 Presumptive eligibility.

457.380 Eligibility verification.

Subpart D -- State Plan Requirements: Coverage and Benefits

457.401 Basis, scope, and applicability.

- 457.402 Definition of child health assistance.
- 457.410 Health benefits coverage options.
- 457.420 Benchmark health benefits coverage.
- 457.430 Benchmark-equivalent health benefits coverage.
- 457.431 Actuarial report for benchmark-equivalent coverage.
- 457.440 Existing comprehensive State-based coverage.
- 457.450 Secretary-approved coverage.
- 457.470 Prohibited coverage.
- 457.475 Limitations on coverage: Abortions.
- 457.480 Preexisting condition exclusions and relation to other laws.
- 457.490 Delivery and utilization control systems.
- 457.495 State assurance of access to care and procedures to assure quality and appropriateness of care.

Subpart E -- State Plan Requirements: Enrollee Financial Responsibilities

- 457.500 Basis, scope, and applicability.
- 457.505 General State plan requirements.

- 457.510 Premiums, enrollment fees, or similar fees: State plan requirements.
- 457.515 Co-payments, coinsurance, deductibles, or similar cost-sharing charges: State plan requirements.
- 457.520 Cost sharing for well-baby and well-child care services.
- 457.525 Public schedule.
- 457.530 General cost-sharing protection for lower income children.
- 457.535 Cost-sharing protection to ensure enrollment of American Indians and Alaska Natives.
- 457.540 Cost-sharing charges for children in families with incomes at or below 150 percent of the FPL.
- 457.555 Maximum allowable cost-sharing charges on targeted low-income children in families with income from 101 to 150 percent of the FPL.
- 457.560 Cumulative cost-sharing maximum.
- 457.570 Disenrollment protections.

**Subpart C -- State Plan Requirements: Eligibility,
Screening, Applications, and Enrollment.**

§457.300 Basis, scope, and applicability.

(a) Statutory basis. This subpart interprets and implements --

(1) Section 2102 of the Act, which relates to eligibility standards and methodologies, coordination with other health insurance programs, and outreach and enrollment efforts to identify and enroll children who are eligible to participate in other public health insurance programs;

(2) Section 2105(c)(6)(B) of the Act, which relates to the prohibition against expenditures for child health assistance provided to children eligible for coverage under other Federal health care programs other than programs operated or financed by the Indian Health Service; and

(3) Section 2110(b) of the Act, which provides a definition of targeted low-income child.

(b) Scope. This subpart sets forth the requirements relating to eligibility standards and to screening, application and enrollment procedures.

(c) Applicability. The requirements of this subpart apply to child health assistance provided under a separate child health program. Regulations relating to eligibility, screening, applications and enrollment that are applicable to a Medicaid expansion program are found at §431.636, §435.4, §435.229, §435.1102, §436.3, §436.229, and §436.1102 of this chapter.

§457.301 Definitions and use of terms.

As used in this subpart--

Joint application means a form used to apply for the separate child health program that, when transmitted to the Medicaid agency following a screening that shows the child is potentially eligible for Medicaid, may also be used to apply for Medicaid.

Qualified entity means an entity that is determined by the State to be capable of making determinations of presumptive eligibility for children, and that --

(1) Furnishes health care items and services covered under the approved plan and is eligible to receive payments under the approved plan;

(2) Is authorized to determine eligibility of a child to participate in a Head Start program under the Head Start Act;

(3) Is authorized to determine eligibility of a child to receive child care services for which financial assistance is provided under the Child Care and Development Block Grant Act of 1990;

(4) Is authorized to determine eligibility of an infant or child to receive assistance under the special nutrition program for women, infants, and children (WIC) under section 17 of the Child Nutrition Act of 1966;

(5) Is an elementary or secondary school, as defined in section 14101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 8801);

(6) Is an elementary or secondary school operated or supported by the Bureau of Indian Affairs;

(7) Is a State or Tribal child support enforcement agency;

(8) Is an organization that is providing emergency food and shelter under a grant under the Stewart B. McKinney Homeless Assistance Act;

(9) Is a State or Tribal office or entity involved in enrollment in the program under Part A of title IV, title XIX, or title XXI; or

(10) Is an entity that determines eligibility for any assistance or benefits provided under any program of public or assisted housing that receives Federal funds, including the program under section 8 or any other section of the United States Housing Act of 1937 (42 U.S.C. 1437) or under the Native American Housing Assistance and Self Determination Act of 1996 (25 U.S.C. 4101 et seq.); or

(11) Any other entity the State so deems, as approved by the Secretary.

Period of presumptive eligibility means a period that begins on the date on which a qualified entity determines that a child is presumptively eligible and ends with the earlier of --

(1) In the case of a child on whose behalf a separate child health program application has been filed, the day on which a decision is made on that application; or

(2) In the case of a child on whose behalf an application for the separate child health program has not

been filed, the last day of the month following the month in which the determination of presumptive eligibility was made.

Public agency means a State, county, city or other type of municipal agency, including a public school district, transportation district, irrigation district, or any other type of public entity.

Presumptive income standard means the highest income eligibility standard established under the plan that is most likely to be used to establish eligibility of a child of the age involved.

§457.305 State plan provisions.

The State plan must include a description of --

(a) The standards, consistent with §§457.310 and 457.320, used to determine the eligibility of children for coverage under the State plan.

(b) The State's policies governing enrollment and disenrollment; processes for screening applicant children for and, if eligible, facilitating their enrollment in Medicaid; and processes for implementing waiting lists and enrollment caps (if any).

§457.310 Targeted low-income child.

(a) Definition. A targeted low-income child is a child who meets the standards set forth below and the eligibility standards established by the State under §457.320.

(b) Standards. A targeted low-income child must meet the following standards:

(1) Financial need standard. A targeted low-income child:

(i) Has a family income at or below 200 percent of the Federal poverty line for a family of the size involved;

(ii) Resides in a State with no Medicaid applicable income level or;

(iii) Resides in a State that has a Medicaid applicable income level and has family income that either --

(A) Exceeds the Medicaid applicable income level for the age of such child, but not by more than 50 percentage points; or

(B) Does not exceed the income level specified for such child to be eligible for medical assistance under policies of the State plan under title XIX on June 1, 1997.

(2) No other coverage standard. A targeted low-income child must not be --

(i) Found eligible or potentially eligible for Medicaid under policies of the State plan (determined through either the Medicaid application process or the screening process described at §457.350); or

(ii) Covered under a group health plan or under health insurance coverage, as defined in section 2791 of the Public Health Service Act, unless the plan or health insurance coverage program has been in operation since before July 1, 1997 and is administered by a State that receives no Federal funds for the program's operation. A child is not considered covered under a group health plan or health insurance coverage if the child does not have reasonable geographic access to care under that plan.

(3) For purposes of this section, policies of the State plan a under title XIX plan include policies under a Statewide demonstration project under section 1115(a) of the Act other than a demonstration project that covered an expanded group of eligible children but that either --

(i) Did not provide inpatient hospital coverage; or

(ii) Limited eligibility to children previously enrolled in Medicaid, imposed premiums as a condition of initial or continued enrollment, and did not impose a general time limit on eligibility.

(c) Exclusions. Notwithstanding paragraph (a) of this section, the following groups are excluded from the definition of targeted low-income children:

(1) Children eligible for certain State health benefits coverage. (i) A targeted low-income child may not be eligible for health benefits coverage under a State health benefits plan in the State on the basis of a family member's employment with a public agency, even if the family declines to accept the coverage.

(ii) A child is considered eligible for health benefits coverage under a State health benefits plan if a more than nominal contribution to the cost of health benefits coverage under a State health benefits plan is available from the State or public agency with respect to the child or would have been available from those sources on November 8, 1999. A contribution is considered more than nominal if the State or public agency makes a contribution toward the cost of an employee's dependent(s) that is \$10 dollars per family, per

month, more than the State or public agency's contribution toward the cost of covering the employee only.

(2) Residents of an institution. A child must not be --

(i) An inmate of a public institution as defined at §435.1009 of this chapter; or

(ii) A patient in an institution for mental diseases, as defined at §435.1009 of this chapter, at the time of initial application or any redetermination of eligibility.

§457.320 Other eligibility standards.

(a) Eligibility standards. To the extent consistent with title XXI of the Act and except as provided in paragraph (b) of this section, the State plan may adopt eligibility standards for one or more groups of children related to --

- (1) Geographic area(s) served by the plan;
- (2) Age (up to, but not including, age 19);
- (3) Income;
- (4) Resources;
- (5) Spenddowns;

(6) Disposition of resources;

(7) Residency, in accordance with paragraph (d) of this section;

(8) Disability status, provided that such standards do not restrict eligibility;

(9) Access to, or coverage under, other health coverage; and

(10) Duration of eligibility, in accordance with paragraph (e) of this section.

(b) Prohibited eligibility standards. In establishing eligibility standards and methodologies, a State may not --

(1) Cover children with a higher family income without covering children with a lower family income within any defined group of covered targeted low-income children;

(2) Deny eligibility based on a preexisting medical condition;

(3) Discriminate on the basis of diagnosis;

(4) Require that any individual provide a social security number (SSN), including the SSN of the applicant child or that of a family member whose income or resources

might be used in making the child's eligibility determination;

(5) Exclude American Indian or Alaska Native children based on eligibility for, or access to, medical care funded by the Indian Health Service;

(6) Exclude individuals based on citizenship or nationality, to the extent that the children are U.S. citizens, U.S. nationals or qualified aliens, (as defined at section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996, as amended by the BBA of 1997, except to the extent that section 403 of PRWORA precludes them from receiving Federal means-tested public benefits); or

(7) Violate any other Federal laws or regulations pertaining to eligibility for a separate child health program under title XXI.

(c) Self-declaration of citizenship. In establishing eligibility for coverage under a separate child health plan, a State may accept self-declaration of citizenship (including nationals of the U.S.), provided that the State has implemented effective, fair, and nondiscriminatory

procedures for ensuring the integrity of its application process.

(d) Residency. The State may establish residency requirements, except that a State may not --

(1) Impose a durational residency requirement;

(2) Preclude the following individuals from declaring residence in a State --

(i) A non-institutionalized child who is not a ward of the State, if the child is physically located in that State, including as a result of the parent's or caretaker's employment in that State;

(ii) An institutionalized child who is not a ward of a State, if the State is the State of residence of the child's custodial parent's or caretaker at the time of placement;

(iii) A child who is a ward of a State, regardless of the child's physical location; or

(iv) A child whose custodial parent or caretaker is involved in work of a transient nature, if the State is the parent's or caretaker's home State.

(e) Duration of eligibility. (1) The State may not impose a lifetime cap or other time limit on the eligibility

of an individual applicant or enrollee, based on the length of time such applicant or enrollee has received benefits under the State's separate child health program.

(2) Eligibility must be redetermined at least every 12 months.

§457.340 Application for and enrollment in a separate child health program.

(a) Application assistance. A State must afford families an opportunity to apply for child health assistance without delay, provided that the State has not reached an approved enrollment cap, and offer assistance to families in understanding and completing applications and in obtaining any required documentation.

(b) Notice of rights and responsibilities. A State must inform applicants at the time of application, in writing and orally if appropriate, about the application and eligibility requirements, the time frame for determining eligibility, and the right to review of eligibility determinations as described in §457.1130.

(c) Timely determinations of eligibility.(1) The agency must promptly determine eligibility and issue a notice of decision within the time standards established,

except in circumstances that are beyond the agency's control.

(2) A State must establish time standards for determining eligibility. These standards may not exceed forty-five calendar days (excluding days during which the application has been suspended, pursuant to §457.350(f)(1)).

(3) In applying the time standards, the State must define "date of application" and must count each calendar day from the date of application to the day the agency mails or otherwise provides notice of its eligibility decision

(d) Notice of decision concerning eligibility. A State must provide each applicant or enrollee a written notice of any decision on the application or other determination concerning eligibility.

(1) If eligibility is approved, the notice must include information on the enrollee's rights and responsibilities under the program, including the opportunity for review of matters described in §457.1130.

(2) If eligibility is denied, suspended or terminated, the State must provide notice in accordance with §457.1180. In the case of a suspension or termination of eligibility, the State must provide sufficient notice to enable the

child's parent or caretaker to take any appropriate actions that may be required to allow coverage to continue without interruption.

(e) Effective date of eligibility. A State must specify a method for determining the effective date of eligibility for its separate child health program, which can be determined based on the date of application or through any other reasonable method.

§457.350 Eligibility screening and facilitation of Medicaid enrollment.

(a) State plan requirement. The State plan must include a description of --

(1) The screening procedures that the State will use, at intake and any follow-up eligibility determination, including any periodic redetermination, to ensure that only targeted low-income children are furnished child health assistance under the plan; and

(2) The procedures that the State will use to ensure that the Medicaid application and enrollment process is initiated and that Medicaid enrollment is facilitated for children found, through the screening process, to be potentially eligible for Medicaid.

(b) Screening objectives. A State must use screening procedures to identify, at a minimum, any applicant or enrollee who is potentially eligible for Medicaid under one of the poverty-level-related groups described in section 1902(1) of the Act, section 1931 of the Act, or a Medicaid demonstration project approved under section 1115 of the Act, applying whichever standard and corresponding methodology generally results in a higher income eligibility level for the age group of the child being screened.

(c) Income eligibility test. To identify the children described in paragraph (b) of this section, a State must either initially apply the gross income test described in paragraph (c)(1) of this section and then use an adjusted income test described in paragraph (c)(2) of this section for applicants whose gross income is above the appropriate Medicaid income standard, or use only the adjusted income test.

(1) Initial gross income test. Under this test, a State initially screens for Medicaid eligibility by comparing gross family income to the appropriate Medicaid income standard.

(2) Adjusted income test. Under this test, a State screens for Medicaid eligibility by comparing adjusted

family income to the appropriate Medicaid income standard. The State must apply Medicaid standards and methodologies relating to income for the particular Medicaid eligibility group, including all income exclusions and disregards, except those that apply only in very limited circumstances.

(d) Resource eligibility test. (1) If a State applies a resource test for children under the Medicaid eligibility group used for screening purposes as described in paragraph (b) of this section and a child has been determined potentially income eligible for Medicaid, the State must also screen for Medicaid eligibility by comparing family resources to the appropriate Medicaid resource standard.

(2) In conducting the screening, the State must apply Medicaid standards and methodologies related to resources for the particular Medicaid eligibility group, including all resource exclusions and disregards, except those that apply only in very limited circumstances.

(e) Children found potentially ineligible for Medicaid. If a State uses a screening procedure other than a full determination of Medicaid eligibility under all possible eligibility groups, and the screening process reveals that the child does not appear to be eligible for Medicaid, the

State must provide the child's family with the following in writing:

(1) A statement that based on a limited review, the child does not appear eligible for Medicaid, but Medicaid eligibility can only be determined based on a full review of a Medicaid application under all Medicaid eligibility groups;

(2) Information about Medicaid eligibility and benefits; and

(3) Information about how and where to apply for Medicaid under all eligibility groups.

(f) Children found potentially eligible for Medicaid.

If the screening process reveals that the child is potentially eligible for Medicaid, the State must establish procedures in coordination with the Medicaid agency that facilitate enrollment in Medicaid and avoid duplicative requests for information and documentation and must --

(1) Except as provided in §457.355, find the child ineligible, provisionally ineligible, or suspend the child's application for the separate child health program unless and until a completed Medicaid application for that child is denied, or the child's circumstances change, and promptly

transmit the separate child health application to the Medicaid agency as provided in paragraph (f)(3)(ii) of this section; and

(2) If a State uses a joint application for its Medicaid and separate child health programs, promptly transmit the application, or the information obtained through the application, and all relevant documentation to the Medicaid agency; or

(3) If a State does not use a joint application for its Medicaid and separate child health programs:

(i) Promptly inform the child's parent or caretaker in writing and, if appropriate, orally that the child has been found likely to be eligible for Medicaid; provide the family with a Medicaid application and offer information about what, if any, further information, documentation, or other steps are needed to complete the Medicaid application process; and offer assistance in completing the application process;

(ii) Promptly transmit the separate child health program application; or the information obtained through the application, and all other relevant information and documentation, including the results of the screening

process, to the Medicaid agency for a final determination of Medicaid eligibility in accordance with the requirements of §§431.636 and 457.1110 of this chapter; or

(4) Establish other effective and efficient procedures, in coordination with the Medicaid agency, as described and approved in the State plan that ensure that children who are screened as potentially eligible for Medicaid are able to apply for Medicaid without delay and, if eligible, are enrolled in Medicaid in a timely manner; and

(5) Determine or redetermine eligibility for the separate child health program, if--

(i) The State is notified pursuant to §431.636 of this chapter that the child has been found ineligible for Medicaid, consistent with the time standards established pursuant to §457.340(c); or

(ii) The State is notified prior to the final Medicaid eligibility determination that the child's circumstances have changed and another screening shows that the child is not likely to be eligible for Medicaid.

(iii) For purposes of such determination or redetermination, the State must not require the child to complete a new application for the separate child health

program, but may require supplemental information to account for any changes in the child's circumstances that may affect eligibility.

(g) Informed application decisions. To enable a family to make an informed decision about applying for Medicaid or completing the Medicaid application process, a State must provide the child's family with information, in writing, about --

(1) The State's Medicaid program, including the benefits covered, and restrictions on cost sharing; and

(2) Eligibility rules that prohibit children who have been screened eligible for Medicaid from being enrolled in a separate child health program, other than provisional temporary enrollment while a final Medicaid eligibility determination is being made.

(h) Waiting lists, enrollment caps and closed enrollment. The State must establish procedures to ensure that --

(1) The procedures developed in accordance with this section have been followed for each child applying for a separate child health program before placing the child on a

waiting list or otherwise deferring action on the child's application for the separate child health program; and

(2) Families are informed that a child may be eligible for Medicaid if circumstances change while the child is on a waiting list for separate child health program.

§457.353 Monitoring and evaluation of screening process.

States must monitor and establish a mechanism to evaluate the screen and enroll process described at §457.350 to ensure that children who are screened potentially eligible for Medicaid are enrolled in Medicaid, if eligible, and that children who are found ineligible for Medicaid are enrolled in the separate child health program, if eligible.

§457.355 Presumptive eligibility.

Consistent with subpart D of this part, the State may pay costs of coverage under a separate child health program, during a period of presumptive eligibility for children applying for coverage under the separate child health program, pending the screening process and a final determination of eligibility (including applicants found through screening to be potentially eligible for Medicaid)

(a) Expenditures for coverage during a period of presumptive eligibility. (1) Expenditures for coverage

during a period of presumptive eligibility for a child ultimately determined eligible for the separate child health program, will be considered, for that period, as expenditures for child health assistance for targeted low-income children under the plan.

(2) Expenditures for coverage during a period of presumptive eligibility implemented in accordance with §435.1101 of this part for a child ultimately determined ineligible for both the separate child health program and Medicaid for that period, and for a child whose family does not complete the Medicaid application process, will be considered as expenditures for targeted low-income children under the plan.

(3) Expenditures for coverage during a period of presumptive eligibility for a child ultimately determined to be eligible for Medicaid may not be considered expenditures under the separate child health program.

§457.380 Eligibility verification.

(a) The State must establish procedures to ensure the integrity of the eligibility determination process.

(b) A State may establish reasonable eligibility verification mechanisms to promote enrollment of eligible

children and may permit applicants and enrollees to demonstrate that they meet eligibility requirements through self-declaration or affirmation except that a State may permit self-declaration of citizenship only if the State has effective, fair and non-discriminatory procedures to ensure the integrity of the application process in accordance with §457.320(c).

Subpart D--State Plan Requirements: Coverage and Benefits

§457.401 Basis, scope, and applicability.

(a) Statutory basis. This subpart interprets and implements --

(1) Section 2102(a)(7) of the Act, which requires that States make assurances relating to, the quality and appropriateness of care, and access to covered services;

(2) Section 2103 of the Act, which outlines coverage requirements for children's health insurance;

(3) Section 2109 of the Act, which describes the relation of the SCHIP program to other laws;

(4) Section 2110(a) of the Act, which describes child health assistance; and

(5) Section 2110(c) of the Act, which contains definitions applicable to this subpart.

(b) Scope. This subpart sets forth requirements for health benefits coverage and child health assistance under a separate child health plan.

(c) Applicability. The requirements of this subpart apply to child health assistance provided under a separate child health program and do not apply to a Medicaid expansion program.

§457.402 Definition of child health assistance.

For the purpose of this subpart, the term "child health assistance" means payment for part or all of the cost of health benefits coverage provided to targeted low-income children for the following services:

(a) Inpatient hospital services.

(b) Outpatient hospital services.

(c) Physician services.

(d) Surgical services.

(e) Clinic services (including health center services) and other ambulatory health care services.

(f) Prescription drugs and biologicals and the administration of these drugs and biologicals, only if these drugs and biologicals are not furnished for the purpose of causing, or assisting in causing, the death, suicide, euthanasia, or mercy killing of a person.

(g) Over-the-counter medications.

(h) Laboratory and radiological services.

(i) Prenatal care and pre-pregnancy family planning services and supplies.

(j) Inpatient mental health services, other than services described in paragraph (18) of this section but including services furnished in a State-operated mental hospital and including residential or other 24-hour therapeutically planned structured services.

(k) Outpatient mental health services, other than services described in paragraph (19) of this section but including services furnished in a State-operated mental hospital and including community-based services.

(l) Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices and adaptive devices).

(m) Disposable medical supplies.

(n) Home and community-based health care services and related supportive services (such as home health nursing services, personal care, assistance with activities of daily living, chore services, day care services, respite care services, training for family members and minor modification to the home.)

(o) Nursing care services (such as nurse practitioner services, nurse midwife services, advanced practice nurse services, private duty nursing, pediatric nurse services and respiratory care services) in a home, school, or other setting.

(p) Abortion only if necessary to save the life of the mother or if the pregnancy is the result of rape or incest.

(q) Dental services.

(r) Inpatient substance abuse treatment services and residential substance abuse treatment services.

(s) Outpatient substance abuse treatment services.

(t) Case management services.

(u) Care coordination services.

(v) Physical therapy, occupational therapy, and services for individuals with speech, hearing and language disorders.

(w) Hospice care.

(x) Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services (whether in a facility, home, school, or other setting) if recognized by State law and only if the service is--

(1) Prescribed by or furnished by a physician or other licensed or registered practitioner within the scope of practice as defined by State law;

(2) Performed under the general supervision or at the direction of a physician; or

(3) Furnished by a health care facility that is operated by a State or local government or is licensed under State law and operating within the scope of the license.

(y) Premiums for private health care insurance coverage.

(z) Medical transportation.

(aa) Enabling services (such as transportation, translation, and outreach services) only if designed to increase the accessibility of primary and preventive health care services for eligible low-income individuals.

(bb) Any other health care services or items specified by the Secretary and not excluded under this subchapter.

§457.410 Health benefits coverage options.

(a) Types of health benefits coverage. States may choose to obtain any of the following four types of health benefits coverage:

(1) Benchmark coverage in accordance with §457.420.

(2) Benchmark-equivalent coverage in accordance with §457.430.

(3) Existing comprehensive State-based coverage in accordance with §457.440.

(4) Secretary-approved coverage in accordance with §457.450.

(b) Required coverage. Regardless of the type of health benefits coverage, described at paragraph (a) of this section, that the State chooses to obtain, the State must obtain coverage for --

(1) Well-baby and well-child care services as defined by the State;

(2) Age-appropriate immunizations in accordance with the recommendations of the Advisory Committee on Immunization Practices (ACIP); and

(3) Emergency services as defined in §457.10.

§457.420 Benchmark health benefits coverage.

Benchmark coverage is health benefits coverage that is substantially equal to the health benefits coverage in one of the following benefit plans:

(a) Federal Employees Health Benefit Plan(FEHBP). The standard Blue Cross/Blue Shield preferred provider option service benefit plan that is described in, and offered to Federal employees under, 5 U.S.C. 8903(1).

(b) State employee plan. A health benefits plan that is offered and generally available to State employees in the State.

(c) Health maintenance organization (HMO) plan. A health insurance coverage plan that is offered through an HMO (as defined in section 2791(b)(3) of the Public Health Service Act) and has the largest insured commercial, non-Medicaid enrollment in the State.

§457.430 Benchmark-equivalent health benefits coverage.

(a) Aggregate actuarial value. Benchmark-equivalent coverage is health benefits coverage that has an aggregate actuarial value determined in accordance with §457.431 that is at least actuarially equivalent to the coverage under one of the benchmark packages specified in §457.420.

(b) Required coverage. In addition to the coverage required under §457.410(b), benchmark-equivalent health benefits coverage must include coverage for the following categories of services:

- (1) Inpatient and outpatient hospital services.
- (2) Physicians' surgical and medical services.
- (3) Laboratory and x-ray services.

(c) Additional coverage. (1) In addition to the categories of services in paragraph (b) of this section,

benchmark-equivalent coverage may include coverage for any additional services specified in §457.402.

(2) If the benchmark coverage package used by the State for purposes of comparison in establishing the aggregate actuarial value of the benchmark-equivalent coverage package includes coverage for prescription drugs, mental health services, vision services or hearing services, then the actuarial value of the coverage for each of these categories of service in the benchmark-equivalent coverage package must be at least 75 percent of the value of the coverage for such a category or service in the benchmark plan used for comparison by the State.

(3) If the benchmark coverage package does not cover one of the categories of services in paragraph (c)(2) of this section, then the benchmark-equivalent coverage package may, but is not required to, include coverage for that category of service.

§457.431 Actuarial report for benchmark-equivalent coverage.

(a) To obtain approval for benchmark-equivalent health benefits coverage described under §457.430, the State must submit to HCFA an actuarial report that contains an

actuarial opinion that the health benefits coverage meets the actuarial requirements under §457.430. The report must also specify the benchmark coverage used for comparison.

(b) The actuarial report must state that it was prepared --

(1) By an individual who is a member of the American Academy of Actuaries;

(2) Using generally accepted actuarial principles and methodologies of the American Academy of Actuaries;

(3) Using a standardized set of utilization and price factors;

(4) Using a standardized population that is representative of privately insured children of the age of those expected to be covered under the State plan;

(5) Applying the same principles and factors in comparing the value of different coverage (or categories of services);

(6) Without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used; and

(7) Taking into account the ability of a State to reduce benefits by considering the increase in actuarial value of health benefits coverage offered under the State plan that results from the limitations on cost sharing (with the exception of premiums) under that coverage.

(c) The actuary who prepares the opinion must select and specify the standardized set and population to be used under paragraphs (b)(3) and (b)(4) of this section.

(d) The State must provide sufficient detail to explain the basis of the methodologies used to estimate the actuarial value or, if requested by HCFA, to replicate the State's result.

§457.440 Existing comprehensive State-based coverage.

(a) General requirements. Existing comprehensive State-based health benefits is coverage that--

(1) Includes coverage of a range of benefits;

(2) Is administered or overseen by the State and receives funds from the State;

(3) Is offered in the State of New York, Florida or Pennsylvania; and

(4) Was offered as of August 5, 1997.

(b) Modifications. A State may modify an existing comprehensive State-based coverage program described in paragraph (a) of this section if--

(1) The program continues to include a range of benefits;

(2) The State submits an actuarial report demonstrating that the modification does not reduce the actuarial value of the coverage under the program below the lower of either--

(i) The actuarial value of the coverage under the program as of August 5, 1997; or

(ii) The actuarial value of a benchmark benefit package as described in §457.430 evaluated at the time the modification is requested.

§457.450 Secretary-approved coverage.

Secretary-approved coverage is health benefits coverage that, in the determination of the Secretary, provides appropriate coverage for the population of targeted low-income children covered under the program. Secretary-approved coverage, for which no actuarial analysis is required, may include --

(a) Coverage that is the same as the coverage provided to children under the Medicaid State plan;

(b) Comprehensive coverage offered by the State under a Medicaid demonstration project approved by the Secretary under section 1115 of the Act that either includes coverage for the full Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit or that the State has extended to the entire Medicaid population in the State;

(c) Coverage that includes benchmark health benefits coverage, as specified in §457.420, plus any additional coverage; or

(d) Coverage, including coverage under a group health plan purchased by the State, that the State demonstrates to be substantially equivalent to or greater than coverage under a benchmark health benefits plan, as specified in §457.420, through use of a benefit-by-benefit comparison of the coverage demonstrating that coverage for each benefit meets or exceeds the corresponding coverage under the benchmark health benefits plan.

§457.470 Prohibited coverage.

A State is not required to provide health benefits coverage under the plan for an item or service for which

payment is prohibited under title XXI even if any benchmark health benefits plan includes coverage for that item or service.

§457.475 Limitations on coverage: Abortions.

(a) General rule. FFP under title XXI is not available in expenditures for an abortion, or in expenditures for the purchase of health benefits coverage that includes coverage of abortion services unless the abortion services meet the conditions specified in paragraph (b) of this section.

(b) Exceptions. (1) Life of mother. FFP is available in expenditures for abortion services when a physician has found that the abortion is necessary to save the life of the mother.

(2) Rape or incest. FFP is available in expenditures for abortion services performed to terminate a pregnancy resulting from an act of rape or incest.

(c) Partial Federal funding prohibited. (1) FFP is not available to a State for any amount expended under the title XXI plan to assist in the purchase, in whole or in part, of health benefits coverage that includes coverage of

abortions other than those specified in paragraph (b) of this section.

(2) If a State wishes to have managed care entities provide abortions in addition to those specified in paragraph (b) of this section, those abortions must be provided under a separate contract using non-Federal funds. A State may not set aside a portion of the capitated rate paid to a managed care entity to be paid with State-only funds, or append riders, attachments or addenda to existing contracts with managed care entities to separate the additional abortion services from the other services covered by the contract.

(3) Nothing in this section affects the expenditure by a State, locality, or private person or entity of State, local, or private funds (other than those expended under the State plan) for any abortion services or for health benefits coverage that includes coverage of abortion services.

§457.480 Preexisting condition exclusions and relation to other laws.

(a) Preexisting condition exclusions. (1) Except as permitted under paragraph (a)(2) of this section, the State

may not permit the imposition of any pre-existing condition exclusion for covered services under the State plan.

(2) If the State obtains health benefits coverage through payment or a contract for health benefits coverage under a group health plan or group health insurance coverage, the State may permit the imposition of a pre-existing condition exclusion but only to the extent that the exclusion is permitted under the applicable provisions of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (ERISA) and title XXVII of the Public Health Service Act.

(b) Relation of title XXI to other laws. (1) ERISA. Nothing in this title affects or modifies section 514 of ERISA with respect to a group health plan as defined by section 2791(a)(1) of the Public Health Service Act.

(2) Health Insurance Portability and Accountability Act (HIPAA). Health benefits coverage provided under a State plan and coverage provided as a cost-effective alternative, as described in subpart J of this part, is creditable coverage for purposes of part 7 of subtitle B of title II of ERISA, title XXVII of the Public Health Service Act, and subtitle K of the Internal Revenue Code of 1986.

(3) Mental Health Parity Act (MHPA). Health benefits coverage under a group health plan provided under a State plan must comply with the requirements of the MHPA of 1996 regarding parity in the application of annual and lifetime dollar limits to mental health benefits in accordance with 45 CFR 146.136.

(4) Newborns and Mothers Health Protection Act (NMHPA). Health benefits coverage under a group health plan provided under a State plan must comply with the requirements of the NMHPA of 1996 regarding requirements for minimum hospital stays for mothers and newborns in accordance with 45 CFR 146.130 and 148.170.

§457.490 Delivery and utilization control systems.

A State that elects to obtain health benefits coverage through a separate child health program must include in its State plan a description of the child health assistance provided under the plan for targeted low-income children, including a description of the proposed methods of delivery and utilization control systems. A State must--

(a) Describe the methods of delivery of child health assistance including the choice of financing and the methods for assuring delivery of the insurance products and delivery

of health care services covered by such products to the enrollees, including any variations; and

(b) Describe utilization control systems designed to ensure that enrollees receiving health care services under the State plan receive only appropriate and medically necessary health care consistent with the benefit package described in the approved State plan.

§457.495 State assurance of access to care and procedures to assure quality and appropriateness of care.

A State plan must include a description of the methods that a State uses for assuring the quality and appropriateness of care provided under the plan, including how the State will assure:

(a) Access to well-baby care, well-child care, well-adolescent care and childhood and adolescent immunizations.

(b) Access to covered services, including emergency services as defined at §457.10.

(c) Appropriate and timely procedures to monitor and treat enrollees with chronic, complex, or serious medical conditions, including access to an adequate number of visits to specialists experienced in treating the specific medical

condition and access to out-of-network providers when the network is not adequate for the enrollee's medical condition.

(d) That decisions related to the prior authorization of health services are completed in accordance with the medical needs of the patient, within 14 days after receipt of a request for services. A possible extension of up to 14 days may be permitted if the enrollee requests the extension or if the physician or health plan determines that additional information is needed.

Subpart E -- State Plan Requirements: Enrollee Financial Responsibilities

§ 457.500 Basis, scope, and applicability.

(a) Statutory basis. This subpart implements --

(1) Section 2101(a) of the Act, which provides that the purpose of title XXI is to provide funds to States to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner; and

(2) Section 2103(e) of the Act, which sets forth provisions regarding State plan requirements and options for cost sharing.

(b) Scope. This subpart consists of provisions relating to the imposition under a separate child health program of cost-sharing charges including enrollment fees, premiums, deductibles, coinsurance, copayments, and similar cost-sharing charges.

(c) Applicability. The requirements of this subpart apply to separate child health programs.

§457.505 General State plan requirements.

The State plan must include a description of --

(a) The amount of premiums, deductibles, coinsurance, copayments, and other cost sharing imposed;

(b) The methods, including the public schedule, the State uses to inform enrollees, applicants, providers and the general public of the cost-sharing charges, the cumulative cost-sharing maximum, and any changes to these amounts;

(c) The disenrollment protections as required under §457.570;

(d) In the case of coverage obtained through premium assistance for group health plans --

(1) The procedures the State uses to ensure that enrollees are not charged copayments, coinsurance, deductibles or similar fees on well-baby and well-child care services described at §457.520, and that any cost sharing complies with the requirements of this subpart;

(2) The procedures to ensure that American Indian and Alaska Native children are not charged premiums, copayments, coinsurance, deductibles, or similar fees in accordance with §457.535;

(3) The procedures to ensure that enrollees are not charged cost sharing in excess of the cumulative cost-sharing maximum specified in §457.560.

(e) Procedures that do not primarily rely on a refund given by the State for overpayment by an enrollee to ensure compliance with this subpart.

§457.510 Premiums, enrollment fees, or similar fees: State plan requirements.

When a State imposes premiums, enrollment fees, or similar fees on enrollees, the State plan must describe --

- (a) The amount of the premium, enrollment fee or similar fee imposed on enrollees;
- (b) The time period for which the charge is imposed;
- (c) The group or groups that are subject to the premiums, enrollment fees, or similar charges;
- (d) The consequences for an enrollee or applicant who does not pay a charge, and the disenrollment protections adopted by the State in accordance with §457.570; and
- (e) The methodology used to ensure that total cost-sharing liability for a family does not exceed the cumulative cost-sharing maximum specified in §457.560.

§457.515 Co-payments, coinsurance, deductibles, or similar cost-sharing charges: State plan requirements.

To impose copayments, coinsurance, deductibles or similar charges on enrollees, the State plan must describe --

- (a) The service for which the charge is imposed;
- (b) The amount of the charge;
- (c) The group or groups of enrollees that may be subject to the cost-sharing charge;

(d) The consequences for an enrollee who does not pay a charge, and the disenrollment protections adopted by the State in accordance with §457.570;

(e) The methodology used to ensure that total cost-sharing liability for a family does not exceed the cumulative cost-sharing maximum specified in §457.560; and

(f) An assurance that enrollees will not be held liable for cost-sharing amounts for emergency services that are provided at a facility that does not participate in the enrollee's managed care network beyond the copayment amounts specified in the State plan for emergency services as defined in §457.10.

§457.520 Cost sharing for well-baby and well-child care services.

(a) A State may not impose copayments, deductibles, coinsurance or other cost sharing with respect to the well-baby and well-child care services covered under the State plan in either the managed care delivery setting or the fee-for-service delivery setting.

(b) For the purposes of this subpart, at a minimum, any of the following services covered under the State plan will be considered well-baby and well-child care services:

(1) All healthy newborn physician visits, including routine screening, whether provided on an inpatient or outpatient basis.

(2) Routine physical examinations as recommended and updated by the American Academy of Pediatrics (AAP) "Guidelines for Health Supervision III" and described in "Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents."

(3) Laboratory tests associated with the well-baby and well-child routine physical examinations as described in paragraph (b)(2) of this section.

(4) Immunizations and related office visits as recommended and updated by the Advisory Committee on Immunization Practices (ACIP).

(5) Routine preventive and diagnostic dental services (such as oral examinations, prophylaxis and topical fluoride applications, sealants, and x-rays) as described in the most recent guidelines issued by the American Academy of Pediatric Dentistry (AAPD).

§457.525 Public schedule.

(a) The State must make available to the groups in paragraph (b) of this section a public schedule that contains the following information:

- (1) Current cost-sharing charges.
- (2) Enrollee groups subject to the charges.
- (3) Cumulative cost-sharing maximums.
- (4) Mechanisms for making payments for required charges.
- (5) The consequences for an applicant or an enrollee who does not pay a charge, including the disenrollment protections required by §457.570.

(b) The State must make the public schedule available to the following groups:

- (1) Enrollees, at the time of enrollment and reenrollment after a redetermination of eligibility, and when cost-sharing charges and cumulative cost-sharing maximums are revised.
- (2) Applicants, at the time of application.
- (3) All participating providers.

(4) The general public.

§457.530 General cost-sharing protection for lower income children.

The State may vary premiums, deductibles, coinsurance, copayments or any other cost sharing based on family income only in a manner that does not favor children from families with higher income over children from families with lower income.

§457.535 Cost-sharing protection to ensure enrollment of American Indians and Alaska Natives.

States may not impose premiums, deductibles, coinsurance, copayments or any other cost-sharing charges on children who are American Indians or Alaska Natives, as defined in §457.10.

§457.540 Cost-sharing charges for children in families with incomes at or below 150 percent of the FPL.

The State may impose premiums, enrollment fees, deductibles, copayments, coinsurance, cost sharing and other similar charges for children whose family income is at or below 150 percent of the FPL as long as --

(a) Aggregate monthly enrollment fees, premiums, or similar charges imposed on a family are less than or equal to the maximum amounts permitted under §447.52 of this chapter for a Medicaid eligible family of the same size and income;

(b) Any copayments, coinsurance, deductibles or similar charges for children whose family income is at or below 100 percent of the FPL are equal to or less than the amounts permitted under §447.54 of this chapter;

(c) For children whose family income is from 101 percent to 150 percent of the FPL, any copayments, coinsurance, deductibles or similar charges are equal to or less than the maximum amounts permitted under §457.555;

(d) The State does not impose more than one type of cost-sharing charge (deductible, copayment, or coinsurance) on a service;

(e) The State only imposes one copayment based on the total cost of services furnished during one office visit; and

(f) Aggregate annual cost sharing of all types, with respect to all targeted low-income children in a family, does not exceed the maximum permitted under §457.560(b).

\$457.555 Maximum allowable cost-sharing charges on targeted low-income children in families with income from 101 to 150 percent of the FPL.

(a) Non-institutional services. For targeted low-income children whose family income is from 101 to 150 percent of the FPL, the State plan must provide that for non-institutional services, including emergency services --

(1) Any copayment or similar charge the State imposes under a fee-for-service delivery system does not exceed the following amounts:

Total cost of services provided during a visit	Maximum amount chargeable to enrollee
\$15.00 or less	\$1.00
\$15.01 to \$40	2.00
\$40.01 to \$80	3.00
\$80.01 or more	5.00

(2) Any copayment that the State imposes for services provided by a managed care organization may not exceed \$5.00 per visit;

(3) Any coinsurance rate the State imposes may not exceed 5 percent of the payment the State directly or through contract makes for the service; and

(4) Any deductible the State imposes may not exceed \$3.00 per month, per family for each period of eligibility.

(b) Institutional services. For targeted low-income children whose family income is from 101 to 150 percent of the FPL, the maximum deductible, coinsurance or copayment charge for each institutional admission may not exceed 50 percent of the payment the State would make under the Medicaid fee-for-service system for the first day of care in the institution.

(c) Institutional emergency services. Any copayment that the State imposes on emergency services provided by an institution may not exceed \$5.00.

(d) Nonemergency use of the emergency room. For targeted low-income children whose family income is from 101 to 150 percent of the FPL, the State may charge up to twice the charge for non-institutional services, up to a maximum amount of \$10.00, for services furnished in a hospital emergency room if those services are not emergency services as defined in §457.10.

(e) Standard copayment amount. For targeted low-income children whose family income is from 101 to 150 percent of the FPL, a standard copayment amount for any service may be determined by applying the maximum copayment

amounts specified in paragraphs (a), (b), and (c) of this section to the State's average or typical payment for that service.

§457.560 Cumulative cost-sharing maximum.

(a) Computation. A State must count cost-sharing amounts that the family has a legal obligation to pay in computing whether a family has met the cumulative cost-sharing maximum. A family will be considered to have a legal obligation to pay amounts a provider actually charges the family for covered services furnished to enrollees, and any other amounts for which payment is required under applicable State law for covered services furnished to eligible children, even if the family never pays those amounts.

(b) Children with family incomes at or below 150 percent of the FPL. For targeted low-income children with family income at or below 150 percent of the FPL, the State may not impose premiums, deductibles, copayments, coinsurance, enrollment fees, or similar cost-sharing charges that, in the aggregate, exceed 2.5 percent of total family income for the length of the child's eligibility period in the State.

(c) Children with family incomes above 150 percent of the FPL. For targeted low-income children with family income above 150 percent of the FPL, the State may not impose premiums, enrollment fees, copayments, coinsurance, deductibles, or similar cost-sharing charges that, in the aggregate, exceed 5 percent of total family income for the length of the child's eligibility period in the State.

(d) The State must inform the enrollee's family in writing and orally if appropriate of their individual cumulative cost-sharing maximum amount at the time of enrollment and reenrollment.

§457.570 Disenrollment protections.

(a) The State must give enrollees reasonable notice of and an opportunity to pay past due premiums, copayments, coinsurance, deductibles or similar fees prior to disenrollment.

(b) The disenrollment process must afford the enrollee an opportunity to show that the enrollee's family income has declined prior to disenrollment for non payment of cost-sharing charges, and in the event that such a showing indicates that the enrollee may have become eligible for Medicaid or for a lower level of cost sharing, the State

must facilitate enrolling the child in Medicaid or adjust the child's cost-sharing category as appropriate.

(c) The State must provide the enrollee with an opportunity for an impartial review to address disenrollment from the program in accordance with §457.1130(a)(3).

Subpart F -- Payments to States

§457.624 [Removed]

8. Section 457.624 is removed.

9. New subparts G, H, I, J, and K are added to read as follows:

Subpart G -- Strategic Planning, Reporting, and Evaluation

Sec.

457.700 Basis, scope, and applicability.

457.710 State plan requirements: Strategic objectives and performance goals.

457.720 State plan requirement: State assurance regarding data collection, records, and reports.

457.740 State expenditures and statistical reports.

457.750 Annual report.

Subpart H -- Substitution of Coverage

- 457.800 Basis, scope, and applicability.
- 457.805 State plan requirements: Procedures to address substitution under group health plans.
- 457.810 Premium assistance programs: Required protections against substitution.

Subpart I -- Program Integrity

- 457.900 Basis, scope, and applicability.
- 457.902 Definitions.
- 457.910 State program administration.
- 457.915 Fraud detection and investigation.
- 457.925 Preliminary investigation.
- 457.930 Full investigation, resolution, and reporting requirements.
- 457.935 Sanctions and related penalties.
- 457.940 Procurement standards.
- 457.945 Certification for contracts and proposals.
- 457.950 Contract and payment requirements including certification of payment-related information.

457.955 Conditions necessary to contract as a managed care entity (MCE).

457.960 Reporting changes in eligibility and redetermining eligibility.

457.965 Documentation.

457.980 Verification of enrollment and provider services received.

457.985 Integrity of professional advice to enrollees.

Subpart J--Allowable Waivers: General Provisions

457.1000 Basis, scope, and applicability.

457.1003 HCFA review of waiver requests.

457.1005 Waiver for cost-effective coverage through a community-based health delivery system.

457.1010 Waiver for purchase of family coverage.

457.1015 Cost-effectiveness.

Subpart K -- State Plan Requirements: Applicant and Enrollee Protections.

457.1100 Basis, scope and applicability.

457.1110 Privacy protections.

457.1120 State plan requirement: Description of review process.

457.1130 Matters subject to review.

457.1140 Core elements of review.

457.1150 Impartial review.

457.1160 Time frames.

457.1170 Continuation of enrollment.

457.1180 Notice.

457.1190 Application of review procedures when States offer premium assistance for group health plans.

Subpart G -- Strategic Planning, Reporting, and Evaluation

§457.700 Basis, scope, and applicability.

(a) Statutory basis. This subpart implements --

(1) Sections 2107(a),(b) and (d) of the Act, which set forth requirements for strategic planning, reports, and program budgets; and

(2) Section 2108 of the Act, which sets forth provisions regarding annual reports and evaluation.

(b) Scope. This subpart sets forth requirements for strategic planning, monitoring, reporting and evaluation under title XXI.

(c) Applicability. The requirements of this subpart apply to separate child health programs and Medicaid expansion programs.

§457.710 State plan requirements: Strategic objectives and performance goals.

(a) Plan description. A State plan must include a description of --

(1) The strategic objectives as described in paragraph (b) of this section;

(2) The performance goals as described in paragraph (c) of this section; and

(3) The performance measurements, as described in paragraph (d) of this section, that the State has established for providing child health assistance to targeted low-income children under the plan and otherwise for maximizing health benefits coverage for other low-income children and children generally in the State.

(b) Strategic objectives. The State plan must identify specific strategic objectives relating to increasing the

extent of creditable health coverage among targeted low-income children and other low-income children.

(c) Performance goals. The State plan must specify one or more performance goals for each strategic objective identified.

(d) Performance measurements. The State plan must describe how performance under the plan is --

(1) Measured through objective, independently verifiable means; and

(2) Compared against performance goals.

(e) Core elements. The State's strategic objectives, performance goals and performance measures must include a common core of national performance goals and measures consistent with the data collection, standard methodology, and verification requirements, as developed by the Secretary.

§457.720 State plan requirement: State assurance regarding data collection, records, and reports.

A State plan must include an assurance that the State collects data, maintains records, and furnishes reports to the Secretary, at the times and in the standardized format the Secretary may require to enable the Secretary to monitor

State program administration and compliance and to evaluate and compare the effectiveness of State plans under title XXI.

§457.740 State expenditures and statistical reports.

(a) Required quarterly reports. A State must submit reports to HCFA that contain quarterly program expenditures and statistical data no later than 30 days after the end of each quarter of the Federal fiscal year. A State must collect required data beginning on the date of implementation of the approved State plan. Territories are exempt from the definition of "State" for purposes of the required quarterly reporting under this section. The quarterly reports must include data on--

(1) Program expenditures;

(2) The number of children enrolled in the title XIX Medicaid program, the separate child health program, and the Medicaid expansion program, as applicable, as of the last day of each quarter of the Federal fiscal year; and

(3) The number of children under 19 years of age who are enrolled in the title XIX Medicaid program, the separate child health program, and in the Medicaid expansion program, as appropriate, by the following categories:

(i) Age (under 1 year of age, 1 through 5 years of age, 6 through 12 years of age, and 13 through 18 years of age).

(ii) Gender, race, and ethnicity.

(iii) Service delivery system (managed care, fee-for-service, and primary care case management).

(iv) Family income as a percentage of the Federal poverty level as described in paragraph (b) of this section.

(b) Reportable family income categories. (1) A State that does not impose cost sharing or a State that imposes cost sharing based on a fixed percentage of income must report by two family income categories:

(i) At or below 150 percent of FPL.

(ii) Over 150 percent of FPL.

(2) A State that imposes a different level or percentage of cost sharing at different poverty levels must report by poverty level categories that match the poverty level categories used for purposes of cost sharing.

(c) Required unduplicated counts. Thirty days after the end of the Federal fiscal year, the State must submit an unduplicated count for the Federal fiscal year of children who were enrolled in the Medicaid program, the separate child health program, and the Medicaid expansion program, as

appropriate, by age, gender, race, ethnicity, service delivery system, and poverty level categories described in paragraphs (a) and (b) of this section.

§457.750 Annual report.

(a) Report required for each Federal fiscal year. A State must report to HCFA by January 1 following the end of each Federal fiscal year, on the results of the State's assessment of the operation of the State plan.

(b) Contents of annual report. In the annual report required under paragraph (a) of this section, a State must--

(1) Describe the State's progress in reducing the number of uncovered, low-income children and; in meeting other strategic objectives and performance goals identified in the State plan; and provide information related to a core set of national performance goals and measures as developed by the Secretary;

(2) Report on the effectiveness of the State's policies for discouraging the substitution of public coverage for private coverage;

(3) Identify successes and barriers in State plan design and implementation, and the approaches the State is considering to overcome these barriers;

(4) Describe the State's progress in addressing any specific issues (such as outreach) that the State plan proposed to periodically monitor and assess;

(5) Provide an updated budget for a 3-year period that describes those elements required in §457.140, including any changes in the sources of the non-Federal share of State plan expenditures;

(6) Identify the total State expenditures for family coverage and total number of children and adults, respectively, covered by family coverage during the preceding Federal fiscal year;

(7) Collect and provide data regarding the primary language of SCHIP enrollees; and

(8) Describe the State's current income standards and methodologies for its Medicaid expansion program, separate child health program, and title XIX Medicaid program, as appropriate.

(c) Methodology for estimate of number of uninsured, low-income children. (1) To report on the progress made in reducing the number of uninsured, low-income children as required in paragraph (b) of this section, a State must choose a methodology to establish an initial baseline

estimate of the number of low-income children who are uninsured in the State.

(i) A State may base the estimate on data from --

(A) The March supplement to the Current Population Survey (CPS);

(B) A State-specific survey;

(C) A statistically adjusted CPS; or

(D) Another appropriate source.

(ii) If the State does not base the estimate on data from the March supplement to the CPS, the State must submit a description of the methodology used to develop the initial baseline estimate and the rationale for its use.

(2) The State must provide an annual estimate of changes in the number of uninsured in the State using --

(i) The same methodology used in establishing the initial baseline; or

(ii) Another methodology based on new information that enables the State to establish a new baseline.

(3) If a new methodology is used, the State must also provide annual estimates based on either the March

supplement to the CPS or the methodology used to develop the initial baseline.

Subpart H -- Substitution of Coverage

§457.800 Basis, scope, and applicability.

(a) Statutory basis. This subpart interprets and implements section 2102(b)(3)(C) of the Act, which provides that the State plan must include a description of procedures the State uses to ensure that health benefits coverage provided under the State plan does not substitute for coverage under group health plans.

(b) Scope. This subpart sets forth State plan requirements relating to substitution of coverage in general and specific requirements relating to substitution of coverage under premium assistance programs.

(c) Applicability. The requirements of this subpart apply to separate child health programs.

§457.805 State plan requirement: Procedures to address substitution under group health plans.

The State plan must include a description of reasonable procedures to ensure that health benefits coverage provided under the State plan does not substitute

for coverage provided under group health plans as defined at §457.10.

§457.810 Premium assistance programs: Required protections against substitution.

A State that operates a premium assistance program, as defined at §457.10, must provide the protections against substitution of SCHIP coverage for coverage under group health plans specified in this section. The State must describe these protections in the State plan; and report on results of monitoring of substitution in its annual reports.

(a) Minimum period without coverage under a group health plan. For health benefits coverage provided through premium assistance for group health plans, the following rules apply:

(1) An enrollee must not have had coverage under a group health plan for a period of at least 6 months prior to enrollment in a premium assistance program. A State may not require a minimum period without coverage under a group health plan that exceeds 12 months.

(2) States may permit reasonable exceptions to the requirement for a minimum period without coverage under a group health plan for --

(i) Involuntary loss of coverage under a group health plan, due to employer termination of coverage for all employees and dependents;

(ii) Economic hardship;

(iii) Change to employment that does not offer dependent coverage; or

(iv) Other reasons proposed by the State and approved as part of the State plan.

(3) The requirement for a minimum period without coverage under a group health plan does not apply to a child who, within the previous 6 months, has received coverage under a group health plan through Medicaid under section 1906 of the Act.

(4) The Secretary may waive the 6-month waiting period requirement described in this section at her discretion.

(b) Employer contribution. For health benefits coverage obtained through premium assistance for group health plans, the employee who is eligible for the coverage must apply for the full premium contribution available from the employer.

(c) Cost effectiveness. In establishing cost effectiveness --

(1) The State's cost for coverage for children under premium assistance programs must not be greater than the cost of other SCHIP coverage for these children; and

(2) The State may base its demonstration of cost effectiveness on an assessment of the cost of coverage for children under premium assistance programs to the cost of other SCHIP coverage for these children, done on a case-by-case basis, or on the cost of premium assisted coverage in the aggregate.

(d) State evaluation. The State must evaluate and report in the annual report (in accordance with §457.750(b)(2)) the amount of substitution that occurs as a result of premium assistance programs and the effect of those programs on access to coverage.

Subpart I -- Program Integrity

§457.900 Basis, scope and applicability.

(a) Statutory basis. This subpart implements --

(1) Section 2101(a) of the Act, which provides that the purpose of title XXI is to provide funds to States to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner; and

(2) Section 2107(e) of the Act, which provides that certain title XIX and title XI provisions, including the following, apply to States under title XXI in the same manner as they apply to a State under title XIX:

(i) Section 1902(a)(4)(C) of the Act, relating to conflict of interest standards.

(ii) Paragraphs (2), (16), and (17), of section 1903(i) of the Act, relating to limitations on payment.

(iii) Section 1903(w) of the Act, relating to limitations on provider taxes and donations.

(iv) Section 1124 of the Act, relating to disclosure of ownership and related information.

(v) Section 1126 of the Act, relating to disclosure of information about certain convicted individuals.

(vi) Section 1128 of the Act, relating to exclusions.

(vii) Section 1128A of the Act, relating to civil monetary penalties.

(viii) Section 1128B(d) of the Act, relating to criminal penalties for certain additional charges.

(ix) Section 1132 of the Act, relating to periods within which claims must be filed.

(b) Scope. This subpart sets forth requirements, options, and standards for program integrity assurances that must be included in the approved State plan.

(c) Applicability. This subpart applies to separate child health programs. Medicaid expansion programs are subject to the program integrity rules and requirements specified under title XIX.

§457.902 Definitions

As used in this subpart --

Actuarially sound principles means generally accepted actuarial principles and practices that are applied to determine aggregate utilization patterns, are appropriate for the population and services to be covered, and have been certified by actuaries who meet the qualification standards established by the Actuarial Standards Board.

Fee-for-service entity means any individual or entity that furnishes services under the program on a fee-for-service basis, including health insurance services.

§457.910 State program administration.

The State's child health program must include --

(a) Methods of administration that the Secretary finds necessary for the proper and efficient operation of the separate child health program; and

(b) Safeguards necessary to ensure that --

(1) Eligibility will be determined appropriately in accordance with subpart C of this part; and

(2) Services will be provided in a manner consistent with administrative simplification and with the provisions of subpart D of this part.

§ 457.915 Fraud detection and investigation.

(a) State program requirements. The State must establish procedures for ensuring program integrity and detecting fraudulent or abusive activity. These procedures must include the following:

(1) Methods and criteria for identifying suspected fraud and abuse cases.

(2) Methods for investigating fraud and abuse cases that --

(i) Do not infringe on legal rights of persons involved; and

(ii) Afford due process of law.

(b) State program integrity unit. The State may establish an administrative agency responsible for monitoring and maintaining the integrity of the separate child health program.

(c) Program coordination. The State must develop and implement procedures for referring suspected fraud and abuse cases to the State program integrity unit (if such a unit is established) and to appropriate law enforcement officials. Law enforcement officials include the--

(1) U.S. Department of Health and Human Services Office of Inspector General (OIG);

(2) U.S. Attorney's Office, Department of Justice (DOJ);

(3) Federal Bureau of Investigation (FBI); and

(4) State Attorney General's office.

§457.925 Preliminary investigation.

If the State agency receives a complaint of fraud or abuse from any source or identifies questionable practices, the State agency must conduct a preliminary investigation or take otherwise appropriate action within a reasonable period of time to determine whether there is sufficient basis to warrant a full investigation.

§457.930 Full investigation, resolution, and reporting requirements.

The State must establish and implement effective procedures for investigating and resolving suspected and apparent instances of fraud and abuse. Once the State determines that a full investigation is warranted, the State must implement procedures including, but not limited to the following:

(a) Cooperate with and refer potential fraud and abuse cases to the State program integrity unit, if such a unit exists.

(b) Conduct a full investigation.

(c) Refer the fraud and abuse case to appropriate law enforcement officials.

§457.935 Sanctions and related penalties.

(a) A State may not make payments for any item or service furnished, ordered, or prescribed under a separate child health program to any provider who has been excluded from participating in the Medicare and Medicaid programs.

(b) The following provisions and their corresponding regulations apply to a State under title XXI, in the same

manner as these provisions and regulations apply to a State under title XIX:

(1) Part 455, subpart B of this chapter.

(2) Section 1124 of the Act pertaining to disclosure of ownership and related information.

(3) Section 1126 of the Act pertaining to disclosure by institutions, organizations, and agencies of owners and certain other individuals who have been convicted of certain offenses.

(4) Section 1128 of the Act pertaining to exclusions.

(5) Section 1128A of the Act pertaining to civil monetary penalties.

(6) Section 1128B of the Act pertaining to criminal penalties for acts involving Federal health care programs.

(7) Section 1128E of the Act pertaining to the reporting of final adverse actions on liability findings made against health care providers, suppliers, and practitioners under the health care fraud and abuse data collection program.

§457.940 Procurement standards.

(a) A State must submit to HCFA a written assurance that title XXI services will be provided in an effective and efficient manner. The State must submit the assurance--

(1) With the initial State plan; or

(2) For States with approved plans, with the first request to amend the approved plan.

(b) A State must --

(1) Provide for free and open competition, to the maximum extent practical, in the bidding of all procurement contracts for coverage or other services in accordance with the procurement requirements of 45 CFR 74.43; or

(2) Use payment rates based on public or private payment rates for comparable services for comparable populations, consistent with principles of actuarial soundness as defined at §457.902.

(c) A State may establish higher rates than permitted under paragraph (b) of this section if such rates are necessary to ensure sufficient provider participation, provider access, or to enroll providers who demonstrate exceptional efficiency or quality in the provision of services.

(d) All contracts under this part must include provisions that define a sound and complete procurement contract, as required by 45 CFR part 74.

(e) The State must provide to HCFA, if requested, a description of the manner in which rates were developed in accordance with the requirements of paragraphs (b) or (c) of this section.

§457.945 Certification for contracts and proposals.

Entities that contract with the State under a separate child health program must certify the accuracy, completeness, and truthfulness of information in contracts and proposals, including information on subcontractors, and other related documents, as specified by the State.

§457.950 Contract and payment requirements including certification of payment-related information.

(a) Managed care entity (MCE). A State that makes payments to an MCE under a separate child health program, based on data submitted by the MCE, must ensure that its contract requires the MCE to provide --

(1) Enrollment information and other information required by the State;

(2) An attestation to the accuracy, completeness, and truthfulness of claims and payment data, under penalty of perjury;

(3) Access for the State, HCFA, and the HHS Office of the Inspector General to enrollee health claims data and payment data, in conformance with the appropriate privacy protections in the State; and

(4) A guarantee that the MCE will not avoid costs for services covered in its contract by referring enrollees to publicly supported health care resources.

(b) Fee-for-service entities. A State that makes payments to fee-for-service entities under a separate child health program must --

(1) Establish procedures to ensure that the entity certifies and attests that information on claim forms is truthful, accurate, and complete;

(2) Ensure that fee-for-service entities understand that payment and satisfaction of the claims will be from Federal and State funds, and that any false claims may be prosecuted under applicable Federal or State laws; and

(3) Require, as a condition of participation, that fee-for-service entities provide the State, HCFA and/or the HHS

Office of the Inspector General with access to enrollee health claims data, claims payment data and related records.

§457.955 Conditions necessary to contract as a managed care entity (MCE).

(a) The State must assure that any entity seeking to contract as an MCE under a separate child health program has administrative and management arrangements or procedures designed to safeguard against fraud and abuse.

(b) The State must ensure that the arrangements or procedures required in paragraph (a) of this section --

(1) Enforce MCE compliance with all applicable Federal and State standards;

(2) Prohibit MCEs from conducting any unsolicited personal contact with a potential enrollee by an employee or agent of a managed care entity for the purpose of influencing the individual to enroll with the entity; and

(3) Include a mechanism for the MCE to report to the State, to HCFA, or to the Office of Inspector General (OIG) as appropriate, information on violations of law by subcontractors or enrollees of an MCE and other individuals.

(c) With respect to enrollees, the reporting requirement in paragraph (b)(3) of this section applies only

to information on violations of law that pertain to enrollment in the plan, or the provision of, or payment for, health services.

(d) The State may inspect, evaluate, and audit MCEs at any time, as necessary, in instances where the State determines that there is a reasonable possibility of fraudulent and abusive activity.

§457.960 Reporting changes in eligibility and redetermining eligibility.

If the State requires reporting of changes in circumstances that may affect the enrollee's eligibility for child health assistance, the State must:

(a) Establish procedures to ensure that enrollees make timely and accurate reports of any such change; and

(b) Promptly redetermine eligibility when the State has information about these changes.

§457.965 Documentation.

The State must include in each applicant's record facts to support the State's determination of the applicant's eligibility for SCHIP.

§457.980 Verification of enrollment and provider services received.

(a) The State must establish methodologies to verify whether beneficiaries have received services for which providers have billed.

(b) The State must establish and maintain systems to identify, report, and verify the accuracy of claims for those enrolled children who meet requirements of section 2105(a) of the Act, where enhanced Federal medical assistance percentage computations apply.

§457.985 Integrity of professional advice to enrollees.

The State must ensure through its contracts for coverage and services that its contractors comply with --

(a) Section 422.206(a) of this chapter, which prohibits interference with health care professionals' advice to enrollees and requires that professionals provide information about treatment in an appropriate manner; and

(b) Sections 422.208 and 422.210 of this chapter, which place limitations on physician incentive plans, and information disclosure requirements related to those physician incentive plans, respectively.

Subpart J--Allowable Waivers: General Provisions**§457.1000 Basis, scope, and applicability.**

(a) Statutory basis. This subpart interprets and implements --

(1) Section 2105(c)(2)(B) of the Act, which sets forth the requirements for a waiver to permit a State to exceed the 10 percent cost limit on expenditures other than benefit expenditures; and

(2) Section 2105(c)(3) of the Act, which permits a waiver for the purchase of family coverage.

(b) Scope. This subpart sets forth requirements for obtaining a waiver under title XXI.

(c) Applicability. This subpart applies to separate child health programs; and applies to Medicaid expansion programs when the State claims administrative costs under title XXI and seeks a waiver of limitations on such claims for use of a community-based health delivery system. This subpart does not apply to demonstrations requested under section 1115 of the Act.

§457.1003 HCFA review of waiver requests.

HCFA will review the waiver requests under this subpart using the same time frames used for State plan amendments, as specified in §457.160.

§457.1005 Waiver for cost-effective coverage through a community-based health delivery system.

(a) Availability of waiver. The Secretary may waive the requirements of §457.618 (the 10 percent limit on expenditures not used for health benefits coverage for targeted low-income children, that meets the requirements of §457.410) in order to provide child health assistance to targeted low-income children under the State plan through a cost-effective, community-based health care delivery system, such as through contracts with health centers receiving funds under section 330 of the Public Health Service Act or with hospitals such as those that receive disproportionate share payment adjustments under section 1886(c)(5)(F) or section 1923 of the Act.

(b) Requirements for obtaining a waiver. To obtain a waiver for cost-effective coverage through a community-based health delivery system, a State must demonstrate that --

(1) The coverage meets all of the requirements of this part, including subpart D and subpart E.

(2) The cost of such coverage, on an average per child basis, does not exceed the cost of coverage under the State plan.

(c) Three-year approval period. An approved waiver remains in effect for no more than 3 years.

(d) Application of cost savings. If the cost of coverage of a child under a community-based health delivery system is equal to or less than the cost of coverage of a child under the State plan, the State may use the difference in the cost of coverage for each child enrolled in a community-based health delivery system for--

(1) Other child health assistance, health services initiatives, or outreach; or

(2) Any reasonable costs necessary to administer the State's program.

§457.1010 Waiver for purchase of family coverage.

A State may purchase family coverage that includes coverage for targeted low-income children if the State establishes that--

(a) Purchase of family coverage is cost-effective under the standards described in §457.1015;

(b) The State does not purchase the coverage if it would otherwise substitute for health insurance coverage that would be provided to targeted, low-income children but for the purchase of family coverage; and

(c) The coverage for the family otherwise meets the requirements of this part.

§457.1015 Cost-effectiveness.

(a) Definition. For purposes of this subpart, "cost-effective" means that the State's cost of purchasing family coverage that includes coverage for targeted low-income children is equal to or less than the State's cost of obtaining coverage under the State plan only for the eligible targeted low-income children involved.

(b) Cost comparisons. A State may demonstrate cost-effectiveness by comparing the cost of coverage for the family to the cost of coverage only for the targeted low-income children under the health benefits package offered by the State under the State plan for which the child is eligible.

(c) Individual or aggregate basis. (1) The State may base its demonstration of the cost-effectiveness of family coverage on an assessment of the cost of family coverage for individual families, done on a case-by-case basis, or on the cost of family coverage in the aggregate.

(2) The State must assess cost-effectiveness in its initial request for a waiver and then annually.

(3) For any State that chooses the aggregate cost method, if an annual assessment of the cost-effectiveness of family coverage in the aggregate reveals that it is not cost-effective, the State must assess cost-effectiveness on a case-by-case basis.

(d) Reports on family coverage. A State with a waiver under this section must include in its annual report pursuant to §457.750, the cost of family coverage purchased under the waiver, and the number of children and adults, respectively, covered under family coverage pursuant to the waiver.

**Subpart K--State Plan Requirements: Applicant and Enrollee
Protections**

§457.1100 Basis, scope and applicability.

(a) Statutory basis. This subpart interprets and implements-

(1) Section 2101(a) of the Act, which states that the purpose of title XXI of the Act is to provide funds to States to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner;

(2) Section 2102(a)(7)(B) of the Act, which requires that the State plan include a description of the methods used to assure access to covered services, including emergency services;

(3) Section 2102(b)(2) of the Act, which requires that the State plan include a description of methods of establishing and continuing eligibility and enrollment; and

(4) Section 2103 of the Act, which outlines coverage requirements for a State that provides child health assistance through a separate child health program.

(b) Scope. This subpart sets forth minimum standards for privacy protection and for procedures for review of

matters relating to eligibility, enrollment, and health services.

(c) Applicability. This subpart only applies to a separate child health program.

§457.1110 Privacy protections.

The State must ensure that, for individual medical records and any other health and enrollment information maintained with respect to enrollees, that identifies particular enrollees (in any form), the State establishes and implements procedures to --

(a) Abide by all applicable Federal and State laws regarding confidentiality and disclosure, including those laws addressing the confidentiality of information about minors and the privacy of minors, and privacy of individually identifiable health information;

(b) Comply with subpart F of part 431 of this chapter;

(c) Maintain the records and information in a timely and accurate manner;

(d) Specify and make available to any enrollee requesting it --

(1) The purposes for which information is maintained or used; and

(2) To whom and for what purposes the information will be disclosed outside the State;

(e) Except as provided by Federal and State law, ensure that each enrollee may request and receive a copy of records and information pertaining to the enrollee in a timely manner and that an enrollee may request that such records or information be supplemented or corrected.

§457.1120 State plan requirement: Description of review process.

A State plan must include a description of the State's review process that meets the requirements of §§457.1130, 457.1140, 457.1150, 457.1160, 457.1170, 457.1180, and 457.1190.

§457.1130 Matters subject to review.

(a) Eligibility or enrollment matter. A State must ensure that an applicant or enrollee has an opportunity for review, consistent with §§457.1140 and 457.1150, of a --

(1) Denial of eligibility;

(2) Failure to make a timely determination of eligibility; and

(3) Suspension or termination of enrollment, including disenrollment for failure to pay cost sharing.

(b) Health services matter. A State must ensure that an enrollee has an opportunity for external review of a --

(1) Delay, denial, reduction, suspension, or termination of health services, in whole or in part, including a determination about the type or level of services; and

(2) Failure to approve, furnish, or provide payment for health services in a timely manner.

(c) Exception. A State is not required to provide an opportunity for review of a matter described in paragraph (a) or (b) of this section if the sole basis for the decision is a provision in the State plan or in Federal or State law requiring an automatic change in eligibility, enrollment, or a change in coverage under the health benefits package that affects all applicants or enrollees or a group of applicants or enrollees without regard to their individual circumstances.

§457.1140 Core elements of review.

In adopting the procedures for review of matters described in §457.1130, a State must ensure that --

(a) Reviews are conducted by an impartial person or entity in accordance with §457.1150;

(b) Review decisions are timely in accordance with §457.1160;

(c) Review decisions are written; and

(d) Applicants and enrollees have an opportunity to --

(1) Represent themselves or have representatives of their choosing in the review process;

(2) Timely review their files and other applicable information relevant to the review of the decision;

(3) Fully participate in the review process, whether the review is conducted in person or in writing, including by presenting supplemental information during the review process; and

(4) Receive continued enrollment in accordance with §457.1170.

§457.1150 Impartial review.

(a) Eligibility or enrollment matter. The review of a matter described in §457.1130(a) must be conducted by a person or entity who has not been directly involved in the matter under review.

(b) Health services matter. The State must ensure that an enrollee has an opportunity for an independent external review of a matter described in §457.1130(b). External review must be conducted by the State or a contractor other than the contractor responsible for the matter subject to external review.

§457.1160 Time frames.

(a) Eligibility or enrollment matter. A State must complete the review of a matter described in §457.1130(a) within a reasonable amount of time. In setting time frames, the State must consider the need for expedited review when there is an immediate need for health services.

(b) Health services matter. The State must ensure that reviews are completed in accordance with the medical needs of the patient. If the medical needs of the patient do not dictate a shorter time frame, the review must be completed within the following time frames:

(1) Standard time frame. A State must ensure that external review, as described in §457.1150(b), is completed within 90 calendar days of the date an enrollee requests internal (if available) or external review. If both internal and external review are available to the enrollee, both types of review must be completed within the 90 calendar day period.

(2) Expedited time frame. A State must ensure that external review, as described in §457.1150(b), is completed within 72 hours of the time an enrollee requests external review, if the enrollee's physician or health plan determines that operating under the standard time frame could seriously jeopardize the enrollee's life or health or ability to attain, maintain or regain maximum function. If the enrollee has access to internal and external review, then each level of review may take no more than 72 hours. The State may extend the 72-hour time frame by up to 14 calendar days, if the enrollee requests an extension.

§457.1170 Continuation of enrollment.

A State must ensure the opportunity for continuation of enrollment pending the completion of review of a suspension or termination of enrollment, including a decision to disenroll for failure to pay cost sharing.

§457.1180 Notice.

A State must provide enrollees and applicants timely written notice of any determinations required to be subject to review under §457.1130 that includes the reasons for the determination, an explanation of applicable rights to review of that determination, the standard and expedited time frames for review, the manner in which a review can be requested, and the circumstances under which enrollment may continue pending review.

§457.1190 Application of review procedures when States offer premium assistance for group health plans.

A State that has a premium assistance program through which it provides coverage under a group health plan that does not meet the requirements of §§457.1130(b), 457.1140, 457.1150(b), 457.1160(b), and 457.1180 must give applicants and enrollees the option to obtain health benefits coverage other than through that group health plan. The State must provide this option at initial enrollment and at each redetermination of eligibility.

(Catalog of Federal Domestic Assistance Program No. 00.000,
State Children's Health Insurance Program)

Dated: _____

Michael M. Hash,

Acting Administrator,

Health Care Financing
Administration.

Dated: _____

Donna E. Shalala,

Secretary.

BILLING CODE 4120-01-P